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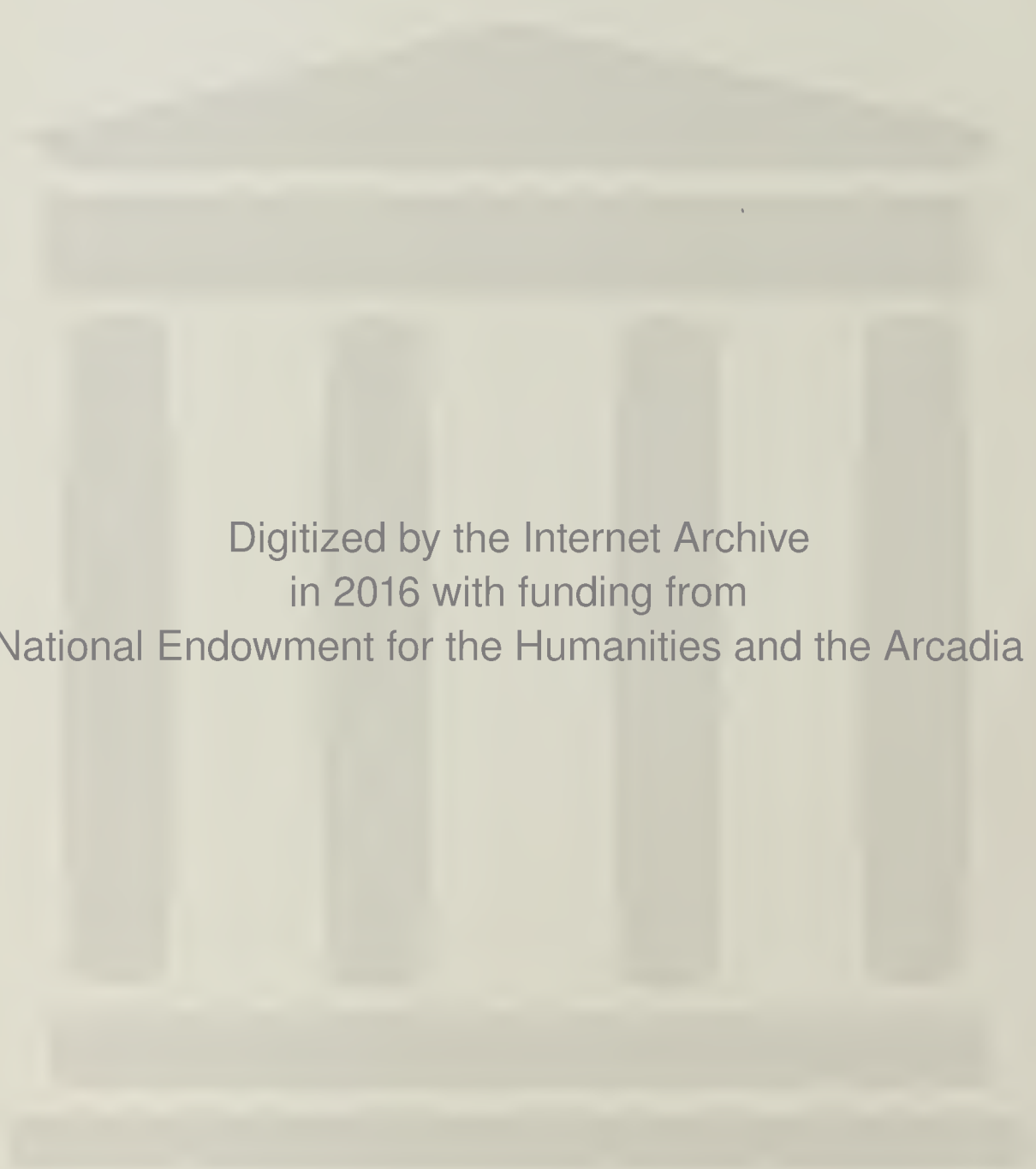












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OF THE

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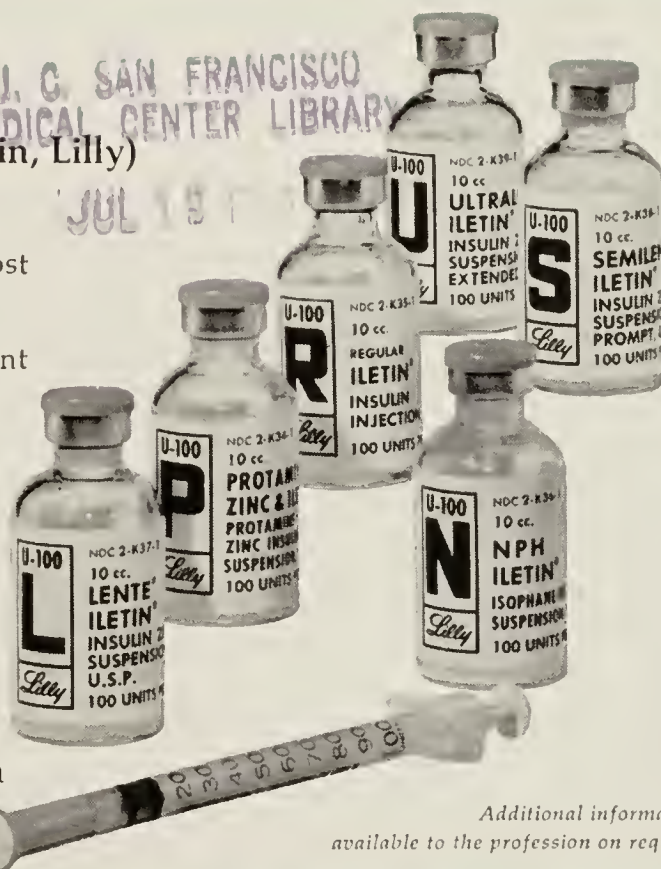
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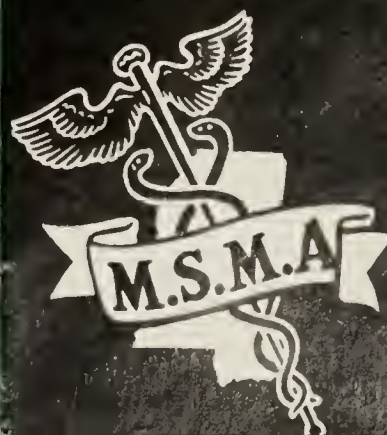
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Volume XIV

Number 7

July 1973



# JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$7.50 per annum; \$1 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri.

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Becomes New Dean of the  
University Medical Center

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**may be more important than his chief complaint**



ORIGINAL PAPERS

## Cardiology for the Practitioner: II. The Medical Management of Angina Pectoris

JAMES R. GALYEAN, III, M.D.

Jackson, Mississippi

THE RECENT SURGE of enthusiasm regarding the surgical treatment of ischemic heart disease reflects a new and exciting approach to the management of that difficult problem. However, important progress in the *medical* treatment of ischemic heart disease has tended to be somewhat overshadowed. Since not all patients are candidates for surgical revascularization of the heart, it is important that physicians be thoroughly familiar with the medical aspects of angina pectoris. In this article, current pharmacological approaches to the treatment of angina will be reviewed. In addition, other factors which influence the symptoms of ischemic heart disease will be analyzed in terms of their effect on myocardial oxygen consumption, and the ways by which these factors may be altered will be discussed.

The first description of the use of nitrites in the treatment of ischemic heart disease was published in 1867 by Sir T. Lauder Brunton, who described the relief of angina pectoris following the inhalation of amyl nitrite.<sup>1</sup> Because of the similarity between the general actions of amyl nitrite and nitroglycerin, William Murrell, in 1879, investigated the latter compound and found that it, too, relieved the pain.<sup>2</sup> Thus, for almost 100 years nitroglycerin has been the most important drug in the symptomatic treatment of angina.

A lively controversy exists as to whether nitroglycerin is effective by virtue of dilatation of coro-

nary arteries or other mechanisms. There is evidence that it acts, at least partially, by directly increasing flow to ischemic myocardium, perhaps

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*Medical management of angina pectoris includes the appropriate use of nitroglycerin, beta adrenergic blocking agents, and, whenever indicated, digitalis and diuretics. The author points out that control of hypertension, cessation of smoking, maintenance of ideal body weight, and appropriate physical exercise are extremely important factors in the medical management of this disease.*

---

most importantly via collateral vessels.<sup>3</sup> It is also well established that nitroglycerin decreases peripheral arteriolar resistance, lowering arterial blood pressure, and increases peripheral venous pooling, decreasing venous return to the heart.<sup>4</sup> These effects decrease ventricular wall tension, one of the primary determinants of myocardial oxygen consumption, tending to relieve angina pectoris irrespective of any direct effect on the coronary circulation.

It is important that the dose of nitroglycerin be tailored to the individual patient. The first several tablets should be given under the observation of the physician, and the dosage should be adjusted to the smallest which gives the appropriate physiologic effect. Goldstein has suggested that a decrease in resting systolic blood pressure of 10-15

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From the Division of Cardiovascular Diseases, Department of Medicine, University of Mississippi Medical Center, Jackson, Miss.



## ANGINA PECTORIS / Galyean

mm. Hg is desirable.<sup>4</sup> When the appropriate dose has been determined, the patient should be instructed to keep nitroglycerin with him at all times, being reminded that it should be kept in a stoppered glass bottle. Nitroglycerin may lose its potency over a prolonged period; it has been empirically determined that there is a characteristic burning or itching sensation under the tongue which occurs when nitroglycerin of effective potency is taken, and, if this is not present, the tablets may have undergone deterioration and should be replaced.<sup>5</sup> Headache should not be used as an indication of the potency of nitroglycerin, because it may bear little relationship to the beneficial cardiovascular effects of the drug.<sup>4</sup>

The patient should be instructed to take a sublingual nitroglycerin tablet at the first indication of pain, and to repeat the dose at five minute intervals for two more doses. If the pain is not relieved after three tablets, the patient usually should be advised to seek immediate medical consultation. However, some patients, particularly those with more severe coronary artery disease, will consistently get no relief for up to 30 minutes; these patients should be told to see their doctor if there is any change in the pattern of their angina or their response to nitroglycerin. Patients should be warned about the possibility of postural hypotension, especially after multiple doses.

The patient should also be instructed in the prophylactic use of nitroglycerin. If there are certain activities which consistently cause angina, such as making up a bed, climbing a staircase, or walking up a steep hill on the golf course, it may be possible to take nitroglycerin beforehand to prevent an attack. If this is effective, the patient should be reassured that it is not harmful to continue. Another important application is in the patient who has given up sexual intercourse because of the consistent angina which it produces; nitroglycerin before intercourse may allow continuation without discomfort.

### LONG-ACTING NITRITES

The use of "long-acting" nitrites is controversial. In optimally controlled clinical trials these preparations do not appear to be more efficacious or longer acting than sublingual nitroglycerin.<sup>4, 6</sup> However, there are some patients who seem to do better with sublingual administration of the "long-acting" nitrite preparations through the day, although a placebo effect may be playing a role. It should be emphasized that these drugs are no substitute for the appropriate use of sublingual

nitroglycerin. The "long-acting" preparations which are to be swallowed, rather than used sublingually, do not appear to be as effective.<sup>7</sup>

In an effort to find longer acting nitrite compounds, interest has been re-directed toward the use of nitroglycerin ointment. Studies at the National Heart and Lung Institute indicate that the therapeutic effect of nitroglycerin ointment may last up to three hours after its application.<sup>8</sup> This may prove useful in patients who must be unavoidably exposed to prolonged periods of stress, such as a business meeting or a court appearance, or in those patients who have nocturnal angina.

### BETA ADRENERGIC BLOCKERS

As myocardial contractility and heart rate are two of the important determinants of myocardial oxygen consumption, it is logical that an agent which decreases these should have an important place in the treatment of angina pectoris. Propranolol (Inderal) is such a drug, and is widely used for the treatment of angina. An additional advantage of the use of beta adrenergic blocking agents is the prevention of the reflex tachycardia which is an undesirable side effect of nitroglycerin. It should be noted that, although many authorities in cardiovascular diseases consider propranolol to be the most important drug to appear for the treatment of angina pectoris since nitroglycerin,<sup>9</sup> it has not been approved for this use by the FDA.

The dosage of propranolol, as nitroglycerin, should be tailored to the individual, as some patients seem to have adequate beta blockade at 40-80 mg. daily, whereas others require dosages as high as 400-500 mg. daily. Since this drug may have undesirable side effects, including exacerbation of heart failure or bronchospasm, it should be administered only by physicians who have experience with its use. Newer beta adrenergic blocking agents which have fewer undesirable side effects have been extensively studied in Great Britain and some of these may eventually replace propranolol in this country.<sup>10</sup>

Digitalis may improve or exacerbate angina pectoris. The reason for this becomes clear when the effect of digitalis is examined in regard to its effect on myocardial oxygen consumption. Digitalis increases myocardial contractility; thus, if this were the only effect of digitalis on the heart, an increase in myocardial oxygen consumption would be expected and angina more likely to occur. Indeed, this frequently occurs when digitalis is given to patients with coronary artery disease who do not have enlarged hearts or congestive heart failure. On the other hand, digitalis reduces

the size of the failing left ventricle. Since ventricular volume is an important determinant of ventricular wall stress, which in turn influences myocardial oxygen consumption, digitalis may importantly decrease the metabolic needs of the failing ventricle, thus relieving angina pectoris. If obvious congestive heart failure is present, digitalis is clearly indicated. In addition, in patients who have angina pectoris which is not responding well to nitroglycerin, particularly if pain occurs in the recumbent position or after the patient has retired at night, a trial of digitalis may produce good results.

Although diuretics do not directly influence myocardial oxygen consumption or coronary blood flow, they may be of help in the treatment of angina pectoris. Arterial blood pressure influences ventricular wall stress, one of the important determinants of myocardial oxygen consumption. The control of hypertension with diuretics, therefore, is an important adjunct to the treatment of angina. In addition, in patients with congestive heart failure ventricular volume may be decreased by treatment with diuretics. Since both ischemia and hypokalemia predispose to dangerous arrhythmias, potassium chloride supplements should usually be given with diuretics of the potassium-wasting type.

#### ANTICOAGULANTS

Although a subject of debate for years, it is now generally agreed that coumarin derivatives are not useful in the treatment of angina pectoris.<sup>6</sup> Drugs which affect platelet function, such as aspirin or dipyridamole (Persantin), and which would be expected to influence thrombogenesis in the arteries may prove worthwhile in the treatment of coronary artery disease,<sup>11</sup> but, at present, there is no evidence that these are useful in the treatment of angina pectoris.

In general, psychopharmacological agents should be avoided since many have undesirable effects on heart rate, blood pressure, and cardiac rhythm. The judicious use of tranquilizers or anti-depressants may become necessary sometimes, but these should not be used without a thorough understanding of their cardiovascular effects.

One of the most important things which the physician can do for his patient is to convince him that he should stop smoking cigarettes, an activity well known to be a precipitating factor in angina.<sup>12</sup> This appears to be most importantly related to a greater heart rate and blood pressure which occur both at rest and during exercise. Additionally, heavy smoking may convert up to 15 per cent of circulating hemoglobin to carboxy-hemoglobin, impairing oxygen delivery.<sup>13</sup> The

importance of the cessation of smoking cannot be overemphasized.

Patients who are obese should be advised to lose weight. For any given degree of physical exertion, a higher blood pressure and heart rate are required in the obese patient, increasing the requirements of the myocardium for oxygen and tending to increase the severity of angina pectoris.

The importance of encouraging patients with ischemic heart disease to engage in well-designed exercise programs is well recognized.<sup>5</sup> It has been suggested that an active exercise program may predispose to the development of coronary collateral circulation, although there is some disagreement regarding this. Regardless of the effect of exercise on collaterals, it is known that subjects who are physically fit may carry out any physical activity with a lower heart rate and blood pressure than those in poor physical condition.<sup>4</sup> As blood pressure and heart rate are important determinants of myocardial oxygen consumption, patients who are physically fit would be expected to have fewer attacks of angina, and this has proven true. In addition, regular exercise may assist the obese patient to lose weight. Patients should be instructed not to exert themselves beyond their limits. Several highly informative reviews of physical activity in patients with ischemic heart disease are available and should be consulted.<sup>14-18</sup>

Although certain lipid abnormalities are fairly well established as risk factors in coronary atherosclerosis, it is not known whether lowering cholesterol or triglycerides reduces the complications of coronary artery disease once it is established.<sup>6</sup> Until this relationship is clear, efforts should be made to control any lipid abnormalities which are present. Although this can usually be done through dietary changes, the use of lipid-lowering drugs will occasionally be necessary. Additionally, dietary instructions are necessary for those patients who need to lose weight.

Although alcohol is known to be a myocardial depressant, an occasional cocktail or wine with a meal is usually not contraindicated, particularly if they provide the patient with a certain degree of relief of emotional stress. It should be remembered, however, that alcohol is calorigenic and it may be more difficult for patients to lose weight if they do not take this into consideration.

It is desirable to change the patient's life as little as possible. Many are able to continue with gainful employment, golfing, fishing, and other enjoyable activities despite angina pectoris. A common sense attitude should prevail. The overprotective doctor may harm his patients by unneces-



sarily limiting their physical activities and causing undue emotional anguish. However, patients should generally be advised to avoid situations which are unusually stressful, as significant increases in blood pressure and heart rate may occur during such times.

Patients who have coronary artery disease are not infrequently hypertensive. As stated previously, arterial blood pressure is one of the important factors in determining the oxygen consumption of the heart, and, therefore, it is extremely important to attain consistently good control of hypertension. Other diseases which may make angina more difficult to control include hyperthyroidism, chronic lung disease, extreme anemia, and various cardiac arrhythmias.

## SUMMARY

Medical management of angina pectoris includes the appropriate use of nitroglycerin, beta adrenergic blocking agents, and, whenever indicated, digitalis and diuretics. Scrupulous attention to the control of blood pressure, cessation of smoking, maintenance of ideal body weight, and appropriate physical exercise are extremely important factors in the medical management of this disease.

★★★

2500 North State Street (39216)

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## MEDICAL ANECDOTE

"Born Free"

"Was your father a doctor?"



# Health Screening for Medicaid Eligible Children in Mississippi: Results of the First Three Years of Screening

FRANK M. WIYGUL, JR., M.D.,  
ALTON B. COBB, M.D., M.P.H.,  
and TERRY W. BECK  
Jackson, Mississippi

MISSISSIPPI physicians are seeing increasing numbers of Medicaid patients under 21 years of age who have been screened and referred through a little known provision of the Medicaid program providing for periodic screening and diagnosis for eligible children. While periodic screening and diagnostic services were provided for in the 1967 amendment to the Social Security Act, all states were slow in implementing this part of the Medicaid program. Mississippi, one of the last states to begin its Medicaid program, became the first to start a comprehensive health screening program designed to bring potential Medicaid patients into the system as early as possible, thus securing the advantages of early diagnosis and treatment. This article is a report of the first three years of this health screening and a review of the findings thus far.

Shortly after the Mississippi Medicaid Act became law in 1969, the Mississippi Medicaid Commission and the Mississippi State Board of Health agreed to begin a periodic screening and diagnostic program on a trial basis to carry out the intent of the federal Medicaid law. The Mississippi plan was to combine the resources of the Medicaid program, the health departments and the welfare departments to implement a periodic screening and diagnostic program utilizing health department facilities, health personnel and supervision to begin a screening program which would meet the federal Medicaid program guidelines. In the Mississippi plan, screening is made available at the community level through a cooperative effort by the county health and welfare departments to bring the children in to scheduled screening clinics. To do this a list of Medicaid eligible children for each county is furnished by the Child Welfare Division of the State Department of Public Wel-

fare; this restricted list is used to prepare appointments which are sent to the families of eligible children. The appointment is signed jointly by the county welfare director and by the health officer.

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*The authors discuss the little-known Medicaid program providing for periodic screening and diagnosis of eligible children and report on the first three years of this screening in Mississippi. The Mississippi Medicaid Commission, the State Board of Health and the State Department of Public Welfare co-operated in the screening program.*

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Families that miss appointments for one reason or another are sent appointments to subsequent clinics. Families who do not come in after several invitations may be visited by the public health nurse, the welfare visitor or by a community outreach worker. Around 50 per cent of the families respond to the first appointment to come in to a screening clinic, and others are reached later by reappointments or outreach.

The Medical Assistance Manual of the Medicaid Program gives the following recommendations for the minimum health screening program: (a) a health and developmental history, (b) an assessment of physical growth, (c) a developmental assessment, (d) vision screening, (e) hearing screening, (f) inspection for obvious physical defects including teeth, gums, eye, ear, nose, mouth and throat, (g) screening test for cardiac abnormalities, (h) hematocrit or hemoglobin, (i) screening for sickle cell anemia and sickle cell trait, (j) screening for lead poisoning, (k) tuberculosis skin test, (l) screening for diabetes, (m) screening for urinary tract infections and other abnormalities, (n) assessment of nutritional sta-

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From the Mississippi Medicaid Commission and the Mississippi State Board of Health.

tus, and (o) immunization review.

The Mississippi program as now carried out includes 13 operations and procedures which cover all of the recommendations in the Medical Assistance Manual except screening for lead poisoning which we do not find necessary in Mississippi. At present developmental assessment is by nurse observation only. We have not yet been able to include standardized developmental assessments. In addition to the above, an exit interview is done for each child and the family is informed of the findings and of the next steps that should be taken. The initial screening utilizes public health nurses and paramedical personnel. Physician staffed backup clinics are held for the evaluation of positive findings. Table I gives the primary screening observations that are carried out. Results from this simple health screening have been surprising. Large numbers of referrals have been made for correctable and treatable conditions. In addition, conditions which create a health hazard have been identified and appropriate referrals made. In the first three years of screening reported here, 36,680 abnormalities have been noted screening include the fact that all of the eligible in 37,331 screening examinations. Table II gives the most frequent and significant findings.

Screening is now being conducted in all counties in the state. Except for the omission of lead screening, we believe that the program meets the Medicaid guidelines. Desirable features of the

population can be identified by the method that we are using, missed appointments can be followed up through health departments and welfare departments, and a number of special services such as special medical clinics, nutrition services, social services and regular preventive medicine practices such as immunizations are available through the program at no additional cost to the Medicaid Commission. Dental services which include preventive dental practices, and the use of dental hygienists in areas where they are available, are being strengthened as rapidly as possible. One of the most helpful features of the screening session is the exit interview in which an experienced public health nurse informs the family of the findings and tells them what to do next.

Weaknesses in the screening program as it is now carried out include the lack of a good feedback mechanism into the program about what happens to referrals that are made to private physicians, and insufficient outreach in some areas for those who do not respond to repeated written invitations to come in to the screening clinics. Possible duplications of services for eligible children who are also in Head Start programs is being eliminated as rapidly as possible by coordination of our examinations with the respective Head Start programs.

An important aspect of this type of health screening which is rarely commented on involves health risk identification. This concept involves the spotting of conditions which are associated with a significant morbidity or mortality before the subject actually has a complication. Examples of conditions which are looked for as potential health hazards are early teenage pregnancy with no prenatal care and children who show evidence of the battered child syndrome. It will be noted that this concept does not necessarily involve medical diagnosis, since the condition may be obvious, but it involves recognizing it and getting the child into an appropriate channel of aid. This is especially important for children who have been outside of the usual systems of care.

One of the frequently heard criticisms of screening procedures conducted in this type of setting is that we are unable to do anything about much of what is found. This is a valid criticism and applies especially to conditions such as dental caries where there are limited resources to provide for dental corrections; however, a closer examination of even such a difficult situation as dental disease shows that a significant number of corrections results from screening. In the case of dental corrections, parents are informed that the

TABLE I  
PEDIATRIC HEALTH SCREENING  
Mississippi Early and Periodic Screening and  
Diagnostic Program

The following screening is done on children (up to 21 years of age) who are covered by the Medical Assistance Act of 1969 (Medicaid):

1. Check sheet health history with parental consent form.
2. Height and weight growth percentile.
3. PhonoCardioScan screening.
4. Visual acuity.
5. Audiometric examination.
6. Ear, nose and throat examination with throat culture if indicated.
7. Tuberculin skin test—Heaf method.
8. Hematocrit, with sickle cell electrophoresis.
9. Physical inspection by a public health nurse.
10. Dipstick urine tests.
11. Blood pressure (over 12).
12. Blood test for serology (over 12).
13. Exit interview with immunization review.



TABLE II  
SUMMARY OF FINDINGS  
January 1, 1970-December 31, 1972

Abnormal PhonoCardioScan	1,973
Arthralgia	375
Asthma (by history)	1,151
Behavior Disorders	251
Breast Mass	14
Bronchitis and Colds (by history)	506
Chest Pain (by history)	257
Child Abuse, Suspected	63
Deaf Mutism	15
Dental Caries, Multiple	10,496
Dental Hygiene, Poor	369
Enuresis	715
Excess Ear Wax	252
Eye Abnormalities, Other	223
Foreign Body in Auditory Canal	16
Headaches, Frequent	656
Hearing, Poor	1,275
Heart Trouble (by history)	66
Hernia, Inguinal	53
Hernia, Umbilical	433
Hernia, Unspecified	52
Hydrocele	18
Hydrocephaly, Suspected	8
Hypertension	327
Impetigo and Other Skin Conditions	1,780
Intestinal Parasites (Hookworm and Roundworm)	2,214
Lacerations	39
Learning and School Difficulties (by history)	142
Low Hematocrit (below 34)	8,384
Low Hematocrit (below 27)	90
Lymph Glands, Enlarged	376
Malnourished	153
Mental Retardation, Obvious	492
Nasal Obstruction	14
Nose Bleeds, Chronic	230
Obesity	586
Orthopedic Deformities	485
Otitis Externa and Otitis Media	1,919
Peridental Abscess	214
Phimosis	16
Pregnancy (unmarried, undiagnosed and no prenatal care)	87
Proteinuria	48
Ptois	5
Ringworm of Scalp	74
Seizure Disorder	493
Sickle Cell Anemia Suspects	50
Speech Defects	178
Throat Cultures	128
Tuberculosis Suspect	13
Tonsils Enlarged and Pharyngitis	4,356
Upper Respiratory Infection	51
Urinary Tract Infection (by history)	187
Visual Acuity, Poor	1,754

child needs dental care and at least some of them manage to get dental work done without help. Others are eligible for emergency dental procedures under the Medicaid program and still others are eligible for dental services provided through a new provision that provides dental services to children under six years of age and which was extended to all Medicaid eligible children July 1, 1973.

Other special services which are provided by recent changes in Medicaid regulations include hearing services and hearing aids for children under nine, and vision services and eye glasses for children under nine. Both of these special services were also extended to all Medicaid eligible children on July 1, 1973. Provision of the special services is through the screening program and by certification in the county health department. Children in special situations such as in the School for the Deaf and other institutions can be given special certification by the county in which they live or by the General Health Services Division of the State Board of Health.

All results of examinations and tests are recorded on each child's health record. Abnormal findings are reviewed by a physician who recommends proper disposition. Children requiring medical attention are referred to their private physician in the area. The Division of General Health Services provides basic services in communities where none is available.

In counties where there are no physicians available, the Division of General Health Services contracts with a pediatrician or another experienced physician to do follow-up examinations, make dispositions and recommend treatment. Public health nurses in the respective counties participate in screening, do follow-up evaluations and carry out treatment under medical direction. The welfare department in each area is advised of positive findings.

## SUMMARY

In a new program, the Mississippi Medicaid Commission, the State Board of Health and the State Department of Public Welfare are cooperating to provide access to medical services and certain special services to Medicaid eligible children through a health screening program carried out in all county health departments. Through the program, 37,331 children have received health screening and some 36,680 abnormal findings have been reported. An opportunity for health screening will be extended to all Medicaid eligible children in the state in the next two years and yearly thereafter.

★★★

313 Dale Building (39216)

# A Study Regarding Sickle Cell Disease in Children of Harrison County Head Start Program, 1971-1972

GILBERT R. MASON, M.D.  
Biloxi, Mississippi

ONLY RECENTLY have America and the world turned their attention to one of the great cripplers of our time. That crippler has been Sickle Cell Disease.

It appears that there is now a growing awareness of Sickle Cell Disease and the federal government and private foundations are aiding in the search for a cure for this genetically linked disease. This action is commendable because Sickle Cell Disease is one of the few biochemical and genetically transmitted diseases whose mechanism of debility is known.

*The author discusses a study performed by the Harrison County Head Start Program in 1971-72. The funds for medical examinations were used to perform complete hemograms and sickle cell studies on the children in the Head Start program. The findings are analyzed and recommendations made.*

It is not the scope of this paper to go into the biochemistry of Sicklemia; but merely to present certain findings as they pertain to the Harrison County Head Start program, and indced, as they pertain to mankind.

Since the Harrison County Head Start program had a limited amount of funds for medical examinations for the year "F" (1971-1972), it was felt that the limited funds would serve a worthwhile purpose through hematological studies.

Complete hemograms and sickle cell studies were the methods chosen and the results of the study are hercinafter set forth (Table 1).

Medical Director, Harrison County Head Start Program.

If a child had a positive sickle cell screening test or indication of unexplained anemia or target cells or bizarre morphological red cells on his periphcral smear and complete blood count, a hemoglobin electrophoresis was ordered.

It is to be noted that initially Memorial Hospital at Gulfport used a modified sodium bisulfite test for sickle cell screening test on the first 295 children with the result of only two positive sickle cell preparations.

Based on well known documented statistical surveys, it was this examiner's opinion that that number was too small so the pathologist at Memorial Hospital was contacted and the Sickledex test was substituted for the modified sodium bisulfite test. The 295 children tested by the latter method were retested using the Sickledex test and the results of that test are used in this analysis.

TABLE 1

		Per Cent
Total number of children studied	1,532	
Total number of black children	1,042	68.2
Total number of white children*	490	31.98

Studies: Complete blood count with differential white cell counts, sickle cell preparations (Sickledex tests\*) and hemoglobin electrophoresis.

Time: Nine months (Head Start program year)

Method: Biloxi D'Iberville Area: Technicians from Howard Memorial Hospital, Biloxi, Mississippi, came to each center and drew blood from children. Gulfport, Long Beach, Pass Christian and Harrison County Areas: Children were transported to Memorial Hospital, Gulfport, Mississippi, for blood to be drawn.

\*Includes Vietnamese (1), Puerto Rican (1), Philippines (3), Mexican American (1).

Howard Memorial Hospital used the Sickledex test throughout.

### FINDINGS

Eighty-four children representing 5.48 per cent of the total Head Start population had positive Sickledex tests. All were black. These 84 black children represented 8.06 per cent of the black enrollment.

Of the 84 black children who had a positive Sickledex test, 81 or 7.77 per cent of the black enrollment had sickle cell trait, two or 0.192 per cent of the black enrollment had actual sickle cell anemia and one or 0.09 per cent had heterozygous hemoglobin SC disease.

It is of interest that because of an abnormal cbc and/or peripheral blood smear, a hemoglobin electrophoresis was ordered and run on one child. This child turned out to have Heterozygous AC Disease.

No white child had a positive Sickledex test.

### CONCLUSIONS

The findings in the Head Start population in Harrison County compare favorably with various surveys made elsewhere in this country.

The genetic influence of the disease is well demonstrated in siblings and kindred from several centers in this county. The time and energy used in this service to the children was well spent for each positive sickler or variant hemoglobin has been counseled by his family physician.

It is this examiner's opinion that the Sickledex test is simple, fast and reliable although false negatives cannot be statistically defined without hemoglobin electrophoresis on every child. Electrophoresis is quite expensive.

### RECOMMENDATIONS

(1) A cbc and Sickledex test should be performed on every black child entering Head Start.

(2) That hemoglobin electrophoresis be utilized for follow-up on all positive children and those with bizarre cbc's and peripheral blood smears.

(3) That the families of children with variants of hemoglobin be counseled by their family physician.

The Medical Director wishes to acknowledge the able assistance and helpful information supplied by all Head Start personnel—especially the former Head Nurse, Mrs. Bessie Rose, the nursing staff, the Director of Social Services, Mrs. Gwen Tretheway, and the laboratories of Howard Memorial Hospital, Biloxi, Mississippi, and Memorial Hospital, Gulfport, Mississippi, and their directors, Dr. Irwin Joffe and Dr. Thomas Walden, respectively. ★★★

433 East Division Street (39530)

This project was carried out as part of Federal Grant H3034 Program Year F for Harrison County Head Start Program under Harrison County Civic Action Committee, Doyle Moffett, Executive Director.

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## STRANGER THAN FICTION

A magician, interviewing an applicant for a job as his assistant, pointed out that he needed somebody who could keep a straight face no matter what strange happenings occurred on stage.

"I'm your man," stated the applicant. "I was the personal secretary of a senator for six years."

—*Standard Flashes*



# Radiologic Seminar CXXIX: Bone Scanning With Technetium Polyphosphate

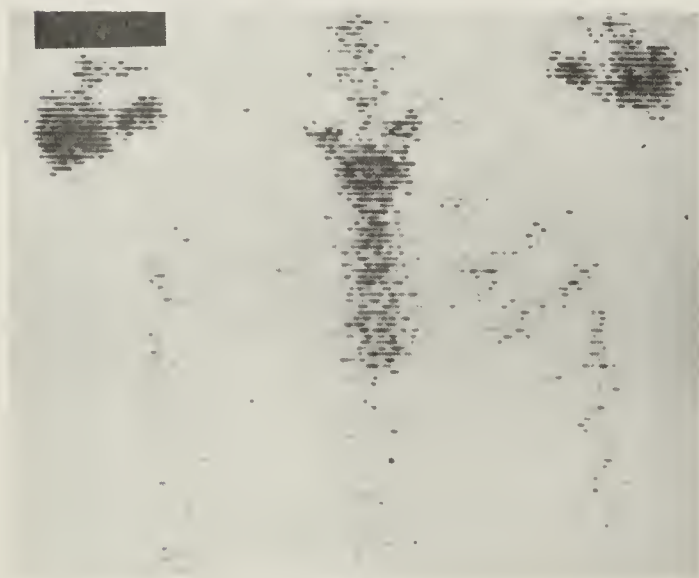
W. M. FLOWERS, JR., M.D.  
Jackson, Mississippi

IT IS OFTEN very difficult to demonstrate tumor metastases in bone by ordinary radiographs. The detection and localization of metastases to the skeleton are obviously necessary for adequate clinical management and we continue to search for more sensitive diagnostic methods. One of the most promising of these is bone scanning.

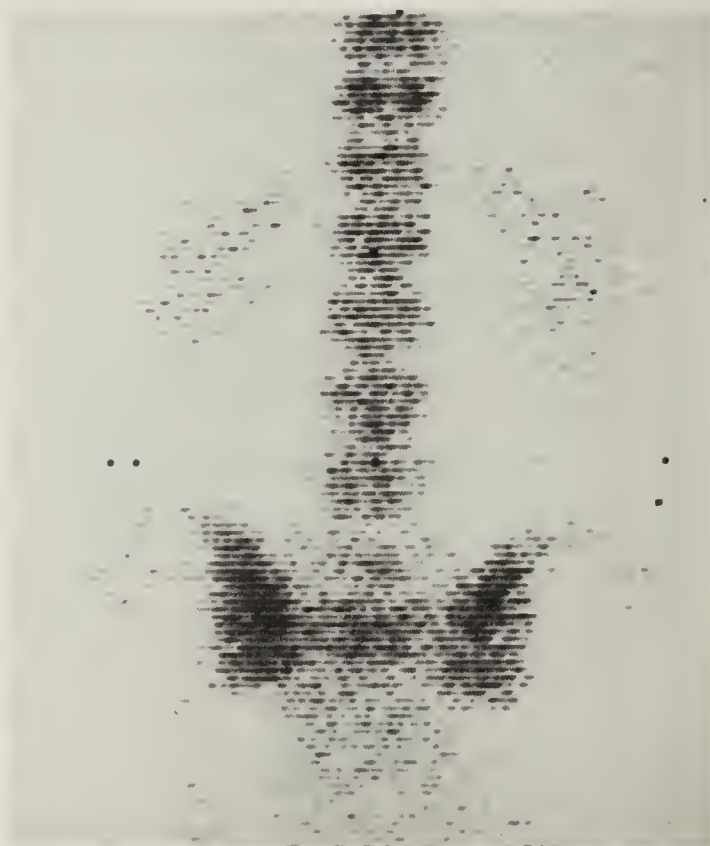
Certain skeletal scanning techniques have been clinically available for over 10 years. The most frequently used isotope, strontium-85, was introduced in 1961. Several other radionuclides, including strontium-87m and fluorine-18 are also available. In spite of their undisputed value in

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Sponsored by the Mississippi Radiological Society.  
From the Division of Nuclear Medicine, Department of  
Radiology, University of Mississippi Medical Center,  
Jackson, Miss.



*Figure 1. Normal bone scan of anterior thorax. There is normal activity in the sternum, ribs, vertebrae, and shoulders.*



*Figure 2. Normal posterior bone scan. There is normal activity in the lower thoracic and lumbo-sacral spine. Activity within the kidneys is also a normal finding.*

skeletal imaging, all these agents have serious disadvantages and limitations. They are high-energy gamma emitters, and available detector systems are not efficient at these energies. Strontium-85 delivers a relatively high radiation dose to the patient, therefore the quantity injected must be small and resulting count rates are quite low. Governmental regulatory agencies limit this nuclide to patients with proven cancer. A delay of three to five days after injection is usually necessary before skeletal activity is good enough for



*Figure 4. Abnormal posterior scan. Pointers show multiple metastases. There are lesions in the pelvis, vertebrae, and ribs. Arrows demonstrate normal activity in kidneys and bladder.*

scanning. Excretion into the bowel can cause areas of increased activity overlying the pelvis and lumbo-sacral spine. Strontium-87m is available from an isotope generator system. The high body background, bowel excretion, short physical half life (2.8 hours) and high photon energy are the chief disadvantages. Fluorine-18 is an excellent scanning agent, but its short half life (1.8 hours) imposes severe restrictions on its availability.

Technetium polyphosphate is a promising new bone scanning agent, currently under extensive clinical investigation in many nuclear medicine facilities. The technetium-99m label is ideal for

*Figure 3. Whole body scan. Arrows show normal activity in the kidneys and bladder. The pointer demonstrates a metastatic lesion in a lumbar vertebra.*

## RADIOLOGIC SEMINAR / Flowers

scanning. This isotope is readily available from a sterile, pyrogen free generator system; it has a physical half life of six hours; there is no beta radiation. These physical properties allow administration of millicurie quantities. The improvement in the resulting scan image is spectacular.

The technetium polyphosphate is prepared quickly and easily by simply adding the isotope to a commercially available vial containing the polyphosphate complex. The properties of this new bone scanning agent have not been completely defined, but approximately 40 per cent of the injected dose is localized in the skeleton. Most of the rest is promptly excreted in the urine. The selective concentration in different regions of bone is probably primarily related to regional blood flow.

This discussion is primarily concerned with the detection of tumor metastases in bone, but the principles of bone scanning are not specific for neoplasm. Normal bone is constantly being formed and resorbed. There is a balance between bone mineral deposition and dissolution. In conditions of bone growth or repair, both formation and resorption may be accelerated. The use of appropriate radioactive tracers allows us to produce

images of bone, and areas of increased skeletal activity can be clearly demonstrated.

Non-uniform tracer distribution occurs normally in both adults and children. An understanding of normal activity patterns is essential for proper scan interpretation. There is localized increased activity around the epiphyses, around the acetabula and sacroiliac joints, and at the ends of the long bones. Most lesions of the skeleton, regardless of etiology, and whether osteoblastic or osteolytic, usually result in focal or diffuse increased activity on bone scans. Occasional lesions show decreased activity. ★★★

2500 North State Street (39216)

The author wishes to express sincere appreciation to Dr. Ottis G. Ball for furnishing two of the illustrations, which were made with the Mississippi Baptist Hospital whole body scanner.

1. Subramanian, G. and McAfee, J. G.: A New Complex for  $^{99m}\text{Tc}$  for Skeletal Imaging. *Radiology* 99:192-196, 1971.
2. O'Mara, R. E. and Subramanian, G.: Experimental Agents for Skeletal Imaging. *Sem. Nuc. Med.* 2:38-49, 1972.
3. Subramanian, G., McAfee, J. G., O'Mara, R. E., et al:  $^{99m}\text{Tc}$ -Polyphosphate pp-46: A New Radiopharmaceutical for Skeletal Imaging. *J. Nuc. Med.* 12:399-400, 1971.
4. Subramanian, G., McAfee, J. G., Bell, E. G. et al:  $^{99m}\text{Tc}$ -Labeled Polyphosphate as a Skeletal Imaging Agent. *Radiology* 102:701-704, 1972.

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## IUD AND CHAMPUS

An intrauterine device (IUD) for contraceptive purposes, ordered by a physician, is an authorized benefit under the family planning provision of the CHAMPUS.



# Constitution and By-Laws of the Mississippi State Medical Association

## CONSTITUTION

### Preamble

That more may live longer in the richness and comfort of health; that pain, suffering, and disease may be eradicated to the extent made possible by scientific medical knowledge; that the standards of the medical profession may be maintained on the highest plane of honor, we dedicate ourselves as physicians through this Association. Among us, membership is a privilege, earned by professional qualification, personal honor, and selfless service; it is not a right vested superficially nor by statutory licensure. Truth shall be our quest; diligence, our staff; and service, our purpose.

### Article I

#### NAME OF THE ASSOCIATION

The name and title of this Association shall be the Mississippi State Medical Association.

### Article II

#### PURPOSE OF ORGANIZATION

The purpose of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of Mississippi and to unite with similar associations in other states to form the American Medical Association, with a view toward the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws, to the promotion of friendly intercourse among the physicians and to guarding and fostering of their opinion in regard to the great problems of medicine, so that the profession shall become more honorable and capable within itself, and more useful to the public in the prevention and care of disease, and in the prolonging of and adding comfort to life.

The purpose of this Association shall be to promote scientific medical research and practice and it shall be a non-profit organization.

### Article III

#### COMPONENT SOCIETIES

Component Societies shall consist of those societies which hold charters from the Association.

### Article IV

#### MEMBERSHIP

Section 1. Members of the Mississippi State Medical Association. Members shall be active, associate, or emeritus, according to requirements and provisions of the By-Laws. There may also be invited guests. Membership other than associate shall be construed as active in connection with the rights and privileges accruing therefrom.

Section 2. Guests. Any physician not a resident of the state may become a guest during any annual session upon invitation of a member of the Association, and shall be accorded the privilege of participating in all the scientific work of that session.

## Article V

### SESSIONS AND MEETINGS

Section 1. The Association shall hold an annual session during which there shall be held daily not less than two general meetings, which shall be open to all registered members and guests.

Section 2. The time and place for holding the annual session shall be fixed by the House of Delegates, but in emergencies, the Board of Trustees shall have the power to fix, or change, either the time or the place, or both of the annual session.

## Article VI

### GENERAL OFFICERS

Section 1. The general officers of this Association shall be a President, President-elect, three Vice-Presidents, one from each Supreme Court District, Secretary-Treasurer, Speaker, Vice Speaker, and Editor.

Section 2. The President, President-elect, and Vice-Presidents shall hold terms of one year. The Secretary-Treasurer, Speaker, Vice Speaker and Editor shall be elected for terms of three years.

Section 3. The officers of this Association shall be elected by the House of Delegates on the last day of the annual session following the adjournment of the general meeting, but no person shall be elected to any such office who has failed to attend two-thirds of the past two and current annual sessions and who has not been a member for the past two years.

Section 4. In addition to these general officers, there shall be an Executive Secretary who need not be a physician or member of the Association. He shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. His compensation and expenses for duties performed shall be fixed by the Board of Trustees and confirmed by the House of Delegates.

## Article VII

### EXECUTIVE OR CENTRAL OFFICES

The Executive Secretary shall maintain in the city of Jackson suitable offices for the discharge of his duties and for conducting the administrative affairs of the Association.

## Article VIII

### HOUSE OF DELEGATES

The House of Delegates shall be the legislative, business, and policy-making body of the Association and shall consist of (1) delegates selected by the component societies under authorized apportionment, (2) the general officers of the Association, (3) all past presidents, provided they still be members in good standing of the Association, (4) members of the Board of Trustees and Councils, and (5) elected committees, Delegates and Alternate Delegates to the American Medical Association, members of the State Board of Health, and members of the Board of Trustees of Mental Institutions, all of whom must be members of this Association.

## Article IX BOARD OF TRUSTEES

The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates and shall perform such duties as are prescribed by law governing directors of corporations and in the By-Laws of the Association. The Board shall consist of nine members, one from each Association District, elected for terms of three years each. A Trustee shall not serve more than three consecutive terms.

## Article X FUNDS AND EXPENSES

Funds for meeting the expenses of the Association shall be arranged for by the House of Delegates by annual dues, per capita assessments upon the membership, and by voluntary contributions. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, publications, and for any other purpose approved by the House of Delegates.

## Article XI THE SEAL

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

## Article XII AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been sent officially to each component society at least two months before the session at which final action is taken.

## BY-LAWS

### Chapter I MEMBERSHIP

Section 1. Eligibility. Each component society of the Mississippi State Medical Association shall judge the qualifications of candidates for election to membership therein, which shall be restricted to those persons who hold the degree of Doctor of Medicine from an appropriately accredited source as defined by the American Medical Association, or in lieu thereof, a foreign degree in medicine which is an acceptable equivalent to the Board of Trustees and shall be a citizen of the United States. All candidates for any degree of membership other than associate must be legally licensed to practice medicine in Mississippi. Persons who obtained this degree prior to January 1, 1917, need not comply with this requirement but must be licensed to practice medicine in Mississippi or, if offering to practice in Mississippi must be eligible for license by reciprocity and be a member in good standing of a constituent (state) association of the American Medical Association. Membership in a component society, evidenced by the payment of dues for the current year, shall be a prerequisite to membership in the Association, except that a physician upon his initial application for membership in a component society of the Association shall be required to undergo a waiting period of ninety (90) consecutive days from the date he begins the practice of medicine in the geographical area of the component society before he may be elected to membership in the component society. No physician shall be eligible for membership

who has been convicted of or who has plead guilty to either a felony or a violation of a state or federal narcotics law. The duly certified court record shall be *prima facie* evidence of pleas and convictions and cause automatic revocation of membership. No physician shall be eligible for election to or continuation of membership who does not possess a currently effective federal narcotics stamp, provided, however, that physicians in full time government service who need no registration to use, prescribe, and dispense narcotic drugs and those who, by reason of type of practice, employment, inactivity, or retirement, neither prescribe nor dispense narcotics and who for this reason alone have not applied for registration shall be exempt from this requirement.

Section 2 (a). Good Standing. Only those members in good standing shall be entitled to the rights and privileges of membership. A physician not in good standing may not be elected to office nor exercise the privilege of voting or attending any session of this Association, scientific or otherwise. The name of a physician upon the properly certified roster of a component society which has paid its annual assessment shall be *prima facie* evidence of his right to register at the annual session of the Mississippi State Medical Association. No member shall participate in any of the proceedings of the annual session until he is duly registered. No delegate or other member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this section. (b) Change of State Residence. In the event that a member moves from the State, his membership shall continue until, and lapse at the end of, the current fiscal year, but this provision shall not operate to prevent a physician who moves from the state continuing his membership by payment of all dues and assessments to the state Association. (c) Obligations of Membership. When the Executive Secretary of the Mississippi State Medical Association is officially informed by the secretary of a component society that a physician is not in good standing in the component society, he shall remove the name of the physician from the rolls of the Association. A member shall hold his membership through the component society in the jurisdiction of which he practices, provided that a physician living on or near a county line may hold membership in the society most convenient for him to attend. If the society in which he chooses to secure membership does not exercise jurisdiction over the area of his residence, then permission must be obtained from the jurisdiction society to facilitate his affiliation with the extra-jurisdiction society.

Section 3. Degrees of Membership. Members of the Mississippi State Medical Association shall be divided into the following classifications: Active, emeritus, and associate. (a) Active Membership. Active members shall include all eligible members of component societies in good standing, providing that all dues and assessments in this Association as may be hereinafter prescribed have been received by the Association. (b) Emeritus Members. Any members of the Mississippi State Medical Association who has been an active member for any ten consecutive years and shall have permanently retired from the practice of medicine shall be eligible for election to emeritus membership. Election to emeritus membership for reason of retirement in the case of permanent and total disability shall merit special consideration but shall be subject to ruling by the Board of Trustees. Election to emeritus membership shall be based on the recommendation of the component society and the approval of the Board of Trustees. (c) Associate Membership. Any commissioned medical officer in the United States Army, United States Air Force, United States Navy, or United States Public Health Service, or any physician in the employ of the Veterans Administration, not licensed to practice in the State of Mississippi, stationed in Mississippi, members of medical faculties of medical schools in Mississippi, approved by the American Medical Association, who are not licensed to practice in the state, any hospital intern, or any hos-



pital resident in Mississippi, may, on election to associate membership by the component society in whose jurisdiction the physician resides become an associate of the Mississippi State Medical Association. Associate members shall not vote or hold office.

Section 4. Dues and Assessments. A per capita assessment determined by the House of Delegates shall constitute the dues of the Association, which assessment shall be collected from all active members by the respective secretaries of the component societies, provided that new members shall be accepted on payment of three-fourths of annual dues after May 1 and one-half of annual dues after September 1. Each active member shall pay the prescribed dues to the officer designated by the component society for transmittal to the Executive Secretary of the Association. Dues shall include a subscription to the official publication of the Association. (a) Members Excused From Payment. The Board of Trustees may, by majority vote, excuse a member from payment of dues because of undue hardship or similar circumstances warranting special consideration provided that the component society shall have excused in full the payment of dues for periods exceeding one year. Such circumstances shall be interpreted to include extended illness and temporary disability. Members who shall have attained age 70 and who have been active members of the Association for any 10 consecutive years may, upon request, be exempt from dues for life effective January 1 after the 70th birthday, and such exemption shall continue so long as the member continues in good standing in his component medical society. (b) Emeritus Members. Physicians who have been elected emeritus members shall not be required to pay dues in the Association. (c) Payment of Dues and Delinquency. Dues of the Association are due and payable on December 31 of the year prior to that for which dues are prescribed. Failure to pay dues by April 1 of the year for which due shall result in forfeiture of membership privileges and the removal of the member's name from the rolls of the Association. A five dollar (\$5.00) reinstatement cost shall be assessed against any member who is delinquent by reason of non-payment of dues after April 1 of the year for which dues are payable. A member in good standing who is called to active duty with the Armed Forces of the United States other than in the regular component shall be carried as an active member without payment of dues until such time as he is released from military service.

Section 5. American Medical Association. Members of this association desiring to be members of the American Medical Association may pay the dues or apply when eligible, for legal exemption from the dues of the American Medical Association. Those desiring to do so may pay their dues to the Executive Secretary whose duty shall be to transmit them to the American Medical Association and to obtain proper credits and receipts therefor.<sup>1</sup>

Section 6. Revocation of Emeritus or Associate Membership. Any emeritus or associate membership may be revoked by two-thirds vote of the House of Delegates when, in the opinion of the House of Delegates, the conduct or actions of the emeritus or associate member violates any of the principles of the code of ethics or whose conduct or actions are not becoming to the honor conferred.

## Chapter II

### ANNUAL AND SPECIAL SESSIONS

Section 1. Time and Place. An annual session shall be held as required by Article V, Section 1, the Constitution of the Mississippi State Medical Association, which session shall in any event be held prior to the annual session of the American Medical Association.

<sup>1</sup> Became effective Jan. 1, 1972.

The place of the state session shall be fixed in accordance with Article V, Section 2, the Constitution of the Mississippi State Medical Association.

Section 2. Special Session. A special session of the Association or of the House of Delegates may be called by the President, with the approval of the Board of Trustees. The Board of Trustees is empowered to call a special session by majority concurrence.

Section 3. Inviting an Annual Session. A component society desiring the Association and House of Delegates to meet in annual session in a city within its jurisdiction may submit an invitation in writing or verbally through its representative to the House of Delegates at the annual session concerned with the selection of the site for the next regular scheduled meeting. The dates and site of the annual session selected may be changed by majority vote of the Board of Trustees in an emergency requiring such a change.

Section 4. Registration Privileges. Only the following shall be permitted to register at any session:

- (a) Active members
- (b) Emeritus members
- (c) Associate members
- (d) Invited guests
- (e) Medical students of American Medical Association approved medical schools who are certified to the Executive Secretary of the Association by their respective deans.
- (f) Interns and residents who are graduates of American Medical Association approved medical schools and who are connected with an approved hospital and who are certified to the Executive Secretary of the Association by their respective hospital superintendents in event they are not associate members of the Association.
- (g) Commissioned medical officers of the United States Armed Forces who are on active duty and who if not associate members are certified to the Executive Secretary by their Post or Base Surgeons or Commanding Officers.

Section 5. Indebtedness. A member shall not be permitted to register unless all current indebtedness to both the Association and component of proper jurisdiction has been paid.

Section 6. Admittance. Admittance to any meeting of the House of Delegates, any scientific section, or any of the various exhibits at an annual session of the Association shall be limited to members in good standing, duly registered and invited guests, members in good standing of the Woman's Auxiliary to the Mississippi State Medical Association, duly accredited and registered members of the Press, and accredited technical and scientific exhibitors.

## Chapter III

### GENERAL MEETING

Section 1. Participation. The general meeting shall include all registered members and guests, who shall have equal rights to participate in the proceedings and discussions, but no member shall vote on any question coming before a section of the general meeting except those who have registered as members of such sections. Each section of the general meeting shall be presided over by its chairman. The address of the President and the Distinguished Service Oration shall be delivered before the general meeting at such time and place as may be arranged.

Section 2. Order. The order of exercise, papers, and discussions as set forth in the official program shall be followed from day to day until it has been completed. But no section shall be allowed to place more than five papers on its program, nor more than two invited guest essayists (out-of-state or non-member). When a section program is not completed within the time assigned, it shall not be allowed to continue into that assigned to another section.

Section 3. Time Restrictions. No address or paper before the Association, except those of the President



and Orator, shall occupy more than twenty minutes in its delivery, except that guests may be allowed thirty minutes; and in formal discussion no one shall speak more than five minutes; and in informal discussion no one shall speak more than three minutes and not more than one time.

Section 4. Essayists. With the exception of the invited guests, the essayists must be members of the Association. No name shall appear more than once on the printed program to discuss a paper before the regular scientific sections unless such person qualifies for membership as provided in these By-Laws.

Section 5. Papers. All papers read before the Association shall be its property. Each paper must be read by its author, and must be deposited with the Secretary when read.

Section 6. Failure to Read Paper. No author listed on the program who fails to read a paper at the session may be allowed a place on the program of the next annual session, but if the author, being unable to attend, shows his good intent by forwarding his paper to the Secretary before the annual session, he shall not suffer the penalty.

## Chapter IV SCIENTIFIC SECTIONS

Section 1. Designation of Sections. The scientific sections of the Association shall be as follows: (a) Section on Medicine, (b) Section on Surgery, (c) Section on Preventive Medicine, (d) Section on Eye, Ear, Nose and Throat, (e) Section on Pediatrics, (f) Section on Obstetrics and Gynecology, and (g) Section on General Practice.

Section 2. Section Officers. Each scientific section of the Association shall, as the last order of business during its regular meeting, elect a chairman who shall serve for a period of one year. A majority of votes cast shall be necessary to elect. Additionally, each section shall elect a secretary whose term of office shall be for a period of three years and so arranged that secretaries shall be elected by their respective sections at the same annual meeting as follows: (1) Sections on General Practice and EENT, (2) Sections on Obstetrics and Gynecology and Preventive Medicine, and (3) Sections on Pediatrics, Surgery, and Medicine.

Section 3. Program. The Council on Scientific Assembly shall place any paper in its proper section. The Council shall so arrange the program that no one section shall be given precedence over others two years in succession.

## Chapter V HOUSE OF DELEGATES

Section 1. Apportionment and Representation. Each organized county shall be entitled to representation in all regular and special sessions of the House of Delegates, one delegate and one alternate for each fifty members in the county and one delegate and one alternate for each fraction thereof, but each organized county holding a charter from this organization having made its annual report and paid its assessments, as provided in this Constitution and By-Laws shall be entitled to at least one delegate and alternate, said alternate delegates to act only in the absence of the delegate or delegates from the respective counties. No county in a component society shall be without representation in the House of Delegates; each shall be entitled to one delegate and one alternate without regard to total membership. No alternate may be seated at any regular or special session of the House of Delegates unless the delegates elected from that county shall be absent or otherwise unable to participate in the proceedings. In the event that neither the delegate nor the alternate is able to attend the regular or special session to which they have been accredited, then any *bona fide* resident of the county may, if properly registered, qualify himself as a delegate. No representative of the component society shall be seated in the

House of Delegates until all his dues, assessments, and obligations to the component society have been paid. Delegates and alternates shall be elected by their respective component societies for terms of not less than two years and shall assume office on the first day of the annual session following their elections; they shall be *bona fide* residents of the counties which they represent. Their names shall be reported to the Central Office of the Association not later than thirty days prior to the first day of the annual session. Representatives of component societies shall be seated in the House of Delegates only following their proper registration of credentials from the component societies they represent.

Section 2. Meetings and Attendance. The House of Delegates shall meet annually on the first day of the annual session of the Association. The House of Delegates shall meet for the conclusion of business on the last day of the annual session immediately following the adjournment of the last general or scientific session, provided that these requirements shall not operate to prevent such other meetings of the House of Delegates during the annual session as the House itself may order or the President or Speaker may deem necessary, but no such meetings may be called at times which would conflict with the scheduled general or scientific session. Duly registered members and guests may attend all meetings of the House of Delegates provided that they occupy a distinctly separate section of the meeting hall or auditorium and further provided that they shall not be permitted to participate in any phase of the meeting of the House of Delegates except on invitation of that body. By majority vote, the House of Delegates may enter into executive session, during which time only qualified delegates and officers of the Association may remain in attendance.

Section 3. Quorum. A three-fifths majority of registered and duly seated delegates of this Association shall constitute a quorum.

Section 4. Order of Business. The order of business shall be conducted at the pleasure of the House of Delegates, provided it shall not be in conflict with either these By-Laws or the Constitution. Meetings shall be conducted according to *Sturgis Standard Code of Parliamentary Procedure*, and within the bounds of courtesy and this Constitution and By-Laws. Generally, the order of business shall be:

- (1) Adoption of the Transactions of the previous meeting.
- (2) Reports of Boards, Councils and Committees.
- (3) Reports of Presidential Committees.
- (4) Special Orders.
- (5) Unfinished Business.
- (6) New Business.

Section 5. Memorials and Resolutions. No memorials or resolutions shall at any time be issued in the name of the Mississippi State Medical Association by any officer or member thereof until such memorial or resolution has been approved and adopted by the House of Delegates or Board of Trustees.

Section 6. Duties and Responsibilities. It shall, through its officers and otherwise, give diligent attention to foster the scientific work and spirit of the Association, and shall constantly study and strive to make each annual session a stepping stone to future ones of higher interest. It shall consider and advise the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto. It shall make careful inquiry into the condition of the profession of each county in the state, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in the counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality, and shall continue these efforts until every



physician in every county in the state has been brought under medical society influence. It shall encourage post-graduate work in medical centers, as well as home study and research, and shall endeavor to have the results utilized and intelligently discussed in the component societies. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body, the term of office to begin on January 1 of the year following that of the elections and continuing for two successive years. It shall, upon recommendation of the Board of Trustees, provide and issue charters to counties organized to conform to the spirit of the Constitution and By-Laws.

Section 7. Reference Committees. Business brought before the House of Delegates will normally be referred by the Speaker for hearing, debate, and recommendation to a reference committee. Sufficient reference committees shall be appointed by the President to expedite and assist in the deliberations of the House of Delegates. Such committees shall consist of not less than three nor more than five members, all of whom shall be members of the House of Delegates, who shall serve only during the regular or special session for which appointed. Any member of the Association shall have the privilege of appearing before a reference committee on any issue being considered. Additionally, reference committees may permit the appearance of any individual who, in the opinion of the committee, can assist its deliberations.

## Chapter VI

### ELECTION OF OFFICERS

Section 1. Ballot. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect.

Section 2. Nominations. The House of Delegates on the first day of the annual session shall select a Committee on Nominations consisting of nine members of the House of Delegates, one from each Association District. It shall be the duty of this committee to consult with the members of the Association and to hold one or more meetings at which the best interests of the Association and of the profession of the state for the ensuing year shall be carefully considered. The committee shall nominate to the House of Delegates three names for each general officer vacancy and two names for all other offices. No two candidates for President-elect may be named from the same county. Nominations for appointment to membership on the Mississippi State Board of Health shall be made by the House of Delegates in accordance with Section 7024, Mississippi Code of 1942, provided that six names shall be submitted, three of whom shall be elected and their names submitted to the Governor as nominees from each district, provided no member shall be nominated who has served two consecutive terms. The House of Delegates shall nominate five physicians when vacancies occur on the Board of Trustees of Mental Institutions which nominations shall be submitted to the Governor in accordance with law.

Section 3. Report of Nominations. The House of Delegates shall receive the report of the Committee on Nominations and elect officers, Trustees, and Council members on the last day of the annual session.

Section 4. Nominations from the Floor. Nothing in this Chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Section 5. Executive Secretary. The Board of Trustees shall select and appoint an Executive Secretary as elsewhere prescribed in the Constitution and By-Laws of the Association.

## Chapter VII

### DUTIES OF OFFICERS

Section 1. President. The President shall have general supervision over all meetings of the various bodies of the Association, shall appoint all committees not otherwise provided for, shall deliver an annual address at such time and place as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall fill by appointment all vacancies occurring during his tenure of office among the general officers and on the Board of Trustees and Councils and shall be empowered to appoint such committees on an *ad hoc* basis as may be desired or required to conduct the affairs of the Association. He shall be an *ex officio* member of all Councils and committees. He shall be the real and acknowledged head, as well as the personal representative, of the medical profession of the State of Mississippi during his term of office, and insofar as practicable, shall visit by appointment the various sections of the state and the component societies of the Mississippi State Medical Association and assist the Trustees in their tasks of aiding and strengthening the component societies and in making their work more useful.

Section 2. President-elect. The President-elect shall be in charge of the work of organization, including membership, under the direction of the President, and shall exercise these duties and advise with the Vice Presidents and with the Board of Trustees in this phase of their activity. He shall be an *ex-officio* member of all Councils and committees. He shall succeed to the presidency upon the event of the death, resignation, or removal from office of the President. This automatic succession shall not operate to disqualify him from serving the next regular term of office unless he has served more than six months as President.

Section 3. Vice Presidents. The Vice Presidents shall assist the President in the discharge of his duties. They shall further assist the President-elect in the work of organization, including membership in their respective areas, and in promoting the welfare of the Association and the profession of the state.

Section 4. Speaker. A Speaker shall be elected for a term of three years. This officer may be chosen from the membership of the Association, irrespective of any affiliation with the House. The Speaker shall familiarize himself with the rules and usages of parliamentary procedure, with the laws of the House. On him shall devolve the duty of bringing before the House through the various officers and chairmen all reports and other matters that are to receive its attention. He shall preside at all meetings of the House and perform the duties usual to the position and office of chairman except in the appointment of committees, which shall be the privilege of the President.

Section 5. Vice Speaker. A Vice Speaker shall be elected for a term of three years to run concurrently with that of the Speaker. The Vice Speaker shall assist the Speaker in all duties prescribed in these By-Laws.

Section 6. Secretary-Treasurer. The Secretary-Treasurer shall be elected for a term of three years. He shall perform such duties ordinarily devolving on a secretary of a corporation by law, custom, or parliamentary usage and shall enjoy the rights and perform such other duties as may be granted or imposed in the Constitution and these By-Laws. He may delegate such duties as are herein described to the Executive Secretary who shall be responsible therefor. He shall be an *ex-officio* member of all Councils and committees.

Section 7. Executive Secretary. The Executive Secretary shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. He need not be a member of the Association nor a physician. He shall maintain a Central Office for the Association and shall be responsible for the management and proper functioning of the Central Office to the President of the Association and the Board of Trustees. He shall attend all sessions and meetings of the Association, the House of Delegates,



the Board of Trustees, and shall serve at all times to perform such other duties as may be deemed beneficial to the Association by the President and Board of Trustees. He shall assist elected officers, Councils, committees, and Trustees in the performance of their duties. Under instructions from the President, he shall conduct a comprehensive program of public education and all such other activities as may disclose favorably to the public at large the aims, objectives, and goals of service of the medical profession in Mississippi. He shall, when requested, place himself in position to assist any of the component societies of the Association and he shall attend meetings of the component societies when invited by officers thereof. He shall be made custodian of records, books and papers belonging to the Association and he shall keep account of and promptly place under the supervision of the Secretary-Treasurer such funds as may be delivered into his hands in the name of the Association. He shall give bond at the expense of the Association in such amount as may be required. He shall provide for the registration of the members and delegates at the annual session and cooperate in preparing for and arranging all functions of the Association, including the annual session. He shall procure an exact transcript of all proceedings of the House of Delegates. He shall maintain a register of all legal practitioners in Mississippi and he shall maintain detailed and exact records of the membership with regard to component societies, the Mississippi State Medical Association, and the American Medical Association. He shall issue evidence of membership to each physician who pays the annual assessment and is accepted in the Mississippi State Medical Association. He shall maintain close and complete liaison with the American Medical Association and shall keep the component societies informed of activities, programs, and mandates of both the state Association and the American Medical Association. He shall publish from the Central Office such memoranda, bulletins, and miscellaneous publications as may be directed by the President, the Board of Trustees, and the House of Delegates. He shall conduct the official correspondence of the Association as he may be directed. He shall employ such assistants as may be required, upon authorization of the Board of Trustees. He shall supply each component society with blank forms to be used in connection with membership and reports. He shall maintain records of monies paid by the component societies for assessments and dues. He shall prepare and publish under the direction of the President and Board of Trustees such programs as may be necessary for official functions of the Association. He shall be reimbursed for expenses incurred in the performance of his duties, separately and in addition to his regular compensation.

## Chapter VIII BOARD OF TRUSTEES

Section 1. Board of Trustees. The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates. It shall consist of nine members, one from each Association District, where terms of office shall be three years and so arranged that only three members are elected annually. A Trustee shall not serve more than three consecutive terms. During vacation, the Board of Trustees shall exercise the powers conferred upon the House of Delegates by the Constitution and these By-Laws, provided that in the exercise of these powers thus conferred, the Board of Trustees shall neither consider nor act to contravene any action, mandate, or policy of the House of Delegates which may still be in effect.

Section 2. Officers of the Board. The Board of Trustees shall elect from its membership a Chairman, a Vice Chairman, and a Secretary for terms of one year during the last day of the annual session following adjournment of the House of Delegates. These officers of the Board shall compose its Executive Committee. The duties of the Secretary may be delegated to the Executive

Secretary who shall maintain such special records and transcripts of meetings as the Board may desire.

Section 3. Meetings of the Board. The Board of Trustees shall meet daily during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of any three members of the Board.

Section 4. Executive Committee. The Executive Committee of the Board of Trustees shall be empowered to act in behalf of the Board on all matters delegated to it by majority vote of the Board. The acts of the Executive Committee, however, shall be subject to confirmation by the Board.

Section 5. Reports of the Board of Trustees. The Board of Trustees shall make an annual report to the House of Delegates and such supplemental reports as necessity may require at a time designated in the regular transaction of the business of the House. The report shall be made by the Chairman, the Vice Chairman, the Secretary, or the Executive Secretary. The reports of the Board shall be made a portion of the annual transactions and proceedings of the Association.

Section 6. Duties of Trustees. Each Trustee shall be organizer and arbiter for his Association District. He shall visit the component medical societies within his District during each year and shall make an annual report of his activities and of the condition of the medical profession of each county of his District. Each Trustee shall be reimbursed for expenses incurred by him in traveling within his District or attending special meetings in the performance of his official duties, which will be allowed upon presentation of an itemized and documented account. This provision shall not be construed to include his expenses in attending the annual session of the Association.

Section 7. Public Policy. The Board of Trustees shall have the right to communicate the views of the medical profession and of the Association in the State of Mississippi with regard to matters of medical science, health, sanitation, and allied spheres of activity. It shall approve all memorials and resolutions issued but shall not issue memorials and resolutions heretofore prohibited in these By-Laws.

Section 8. Association Districts. The State of Mississippi shall be subdivided into Association Districts by counties, provided that all counties in a component society shall be in one Association District. These districts are defined as follows:

- District 1: Bolivar, Coahoma, Humphreys, Leflore, Quitman, Sunflower, Tallahatchie, Tunica, and Washington.
- District 2: Benton, DeSoto, Lafayette, Marshall, Panola, Tate, Tippah, and Yalobusha.
- District 3: Alcorn, Calhoun, Chickasaw, Clay, Itawamba, Lee, Lowndes, Monroe, Noxubee, Oktibbeha, Pontotoc, Prentiss, Tishomingo, and Union.
- District 4: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, and Webster.
- District 5: Hinds, Issaquena, Leake, Madison, Rankin, Scott, Sharkey, Simpson, Smith, Warren, and Yazoo.
- District 6: Clark, Kemper, Lauderdale, Neshoba, Newton, and Winston.
- District 7: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Pearl River, Perry, and Wayne.
- District 8: Adams, Amite, Claiborne, Copiah, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, and Wilkinson.
- District 9: Hancock, Harrison, Jackson, and Stone.

## Chapter IX COUNCILS

Section 1. Councils. Councils of the Association shall be elected standing bodies of the House of Delegates, responsible thereto. There shall be a Council on Medical



Service, a Council on Scientific Assembly, a Judicial Council, a Council on Constitution and By-Laws, a Council on Legislation, a Council on Budget and Finance, an Editorial Council, and a Council on Medical Education. A Council member shall not serve more than three consecutive terms.

Section 2. Council on Medical Service. The Council on Medical Service shall be charged with the responsibilities of ascertaining and studying all aspects of medical care in Mississippi. It shall examine and make available all facts, data, and opinion on timely and adequate medical care. It shall investigate social and economic aspects of medical care and report its evaluations and findings. It shall suggest means of distribution of adequate quality medical service to the public consistent with the policies of the Association. It shall act as a factfinding and advisory body of the Association. Under its jurisdictions, there shall be assigned the activities of the Association in medical service, emergency service programs, indigent care, and allied medical agencies. There shall be one member from each Association District elected for a term of three years and so arranged that only three members shall be elected for full terms each year. The Council on Medical Service shall appoint Committees on Occupational Health, Maternal and Child Care, Mental Health, Blood and Blood Banking, and Nursing. Each committee shall consist of not less than five nor more than seven members appointed for periods of not less than one nor more than three years.

Section 3. Council on Scientific Assembly. The Council on Scientific Assembly shall be composed of the Secretary-Treasurer and the chairman and secretaries of the several scientific sections. The Secretary-Treasurer shall be chairman of the Council. Upon this Council shall devolve the duties and responsibilities of planning the annual session to include all scientific activity and the programming and scheduling of annual session events. The Council shall be empowered to appoint such committees for terms not to exceed one year as may be necessary to assist in the discharge of these duties.

Section 4. Judicial Council. The Judicial Council shall consist of nine members elected for terms of three years each, one from each Association District. The judicial powers of the Association shall be vested in this Council whose decision shall be final. The Council shall have jurisdiction in all questions involving membership in the Association, all controversies arising under the Constitution and these By-Laws, interpretation and application of the Principles of Medical Ethics of the American Medical Association, controversies between two or more component societies of the Association and among members of the Association. The Council shall have appellate jurisdiction in questions and controversies referred to the state Association by appropriate and authorized bodies of component medical societies. Appeals shall be perfected within six months following the date of decision by the constituted authority of the component society. The Council, under these several authorities, may conduct such hearings as may be necessary and after due and legal processes may, by majority opinion, censure, suspend, or expel any member for infraction of the Constitution or these By-Laws.

Section 5. Council on Constitution and By-Laws. The Council on Constitution and By-Laws shall consist of three members elected by the House of Delegates for terms of three years each. To this Council shall be referred all suggested amendments and changes in the Constitution and By-Laws of the Association for recommendation to the Board of Trustees and House of Delegates.

Section 6. Council on Legislation. The Council on Legislation shall consist of nine members, one from each association district, elected by the House of Delegates for terms of three years each which are so arranged that three members are elected annually. This Council shall analyze proposed legislation, recommending to the Board of Trustees courses of action for securing laws in the in-

terests of public health, scientific medicine, as well as medical practice. It shall study and report the need for new and remedial legislation designed to serve the best interests of the state and nation. This Council shall be responsible to the Board of Trustees.

Section 7. Council on Budget and Finance. The Council on Budget and Finance shall consist of five members elected by the House of Delegates for terms of three years each which are so arranged that not more than two members shall be elected annually. This Council shall receive reports of the finances of the Association and to it shall be referred all matters pertaining to the annual budget. The Council shall report annually to the House of Delegates, making specific recommendations on the annual budget of the Association. This Council shall be responsible to the Board of Trustees.

Section 8. Editorial Council. The Editorial Council shall consist of the Editor and the Associate Editors, elected by the House of Delegates to serve two years, and the former shall serve as chairman. To this Council shall be referred all reports of scientific subjects and all scientific papers and discussions presented before the Association and its component societies. The Council shall consider for publication in the official organ of the Association such papers, reports, and other data as may serve to further and advance scientific medicine in Mississippi. It shall exercise editorial authority over the official organ of the Association. This Council shall be responsible to the Board of Trustees.

Section 9. Council on Medical Education. The Council on Medical Education shall consist of three members elected by the House of Delegates for terms of three years each. To this Council shall be assigned the responsibilities of encouraging undergraduate and postgraduate study of medicine, licensure, and facilities for medical education in the state. This Council shall be responsible to the Board of Trustees.

## Chapter X

### COMMITTEES OF THE BOARD OF TRUSTEES

Section 1. Committees of the Board of Trustees. Standing committees of the Board of Trustees shall consist of the Advisory Committee to the Medical Auxiliary, Peer Review Committee, the Committee on Publications, and the Committee on Medicine and Religion. All committees of the Board of Trustees shall be appointed by the Board for terms specified unless their selection is otherwise prescribed.

Section 2. Advisory Committee to the Medical Auxiliary. The Advisory Committee to the Medical Auxiliary shall consist of three members appointed for terms of three years each. The committee shall be charged with the responsibility of advising the Woman's Auxiliary to the Mississippi State Medical Association on matters of organization and program activity relating to the supportive role of the Auxiliary in its work with the Association.

Section 3. Peer Review. The Committee on Peer Review shall consist of nine members, one from each Association district, appointed for terms of three years each so as to provide for appointment of three members annually. Members of this committee shall not simultaneously serve on any disciplinary body of the Association or its component medical societies. To this committee shall be assigned the work of peer review, including but not limited to resolution of differences between patient and physician, review of the quality of medical care, adequacy and/or reasonableness of fees, whether due or paid from private or public sources, utilization of health care resources, and liaison with private and public sources of medical care financing. The committee is empowered to encourage a response from any member of the Association in writing or by personal appearance, authority to initiate investigations on its own motion, and authority to file charges against a member in the name of the



committee before the Judicial Council or a disciplinary body of a component medical society. Under no circumstances, however, shall the Committee on Peer Review exercise any disciplinary function nor shall it be empowered to alter the status or standing of any member. The committee shall be empowered to prescribe its rules of operation which shall not be in conflict with the policies or By-Laws of the Association. The committee shall also encourage and assist component medical societies in forming Committees on Peer Review at the local level.

Section 4. Committee on Publications. The Committee on Publications shall consist of six members. These shall consist of the Editor, the two Associate Editors, and three others, the three latter being appointed by the Board of Trustees for terms of three years which are so arranged to provide for appointment of one such member annually. The chairman of the committee shall be designated by the Board. The committee shall implement instructions and policies of the Board of Trustees relating to the official Journal of the Association. Additionally, the committee shall study and recommend to the Board policy proposals relating to organization and production of the Journal, reporting annually its deliberations.

Section 5. Committee on Medicine and Religion. The Committee on Medicine and Religion shall consist of six members appointed for terms of three years each and so arranged to provide for appointment of two members annually. The committee shall be responsible for formulating a program in the field of medicine and religion and for carrying out such assignments as may be made in this connection by the Board of Trustees.

Section 6. Committee on Long-Range Planning. The Committee on Long-Range Planning shall consist of five members appointed for terms of five years each and so arranged to provide for appointment of one member annually. This committee shall receive charges from the Board of Trustees and shall assess developments and requirements in fields of association activity, making recommendations for courses of action to achieve maximum possible effectiveness in all fields of association activity.

## Chapter XI RULES AND CONDUCT

*The Principles of Medical Ethics of the American Medical Association* shall govern the conduct of members in their relations to each other and to the public.

## Chapter XII COMPONENT SOCIETIES

Section 1. Component Societies. All component societies now in affiliation with this Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Board of Trustees and approval by the House of Delegates, receive a charter from and become a component part of this Association. The Board of Trustees and House of Delegates, on recommendation by the Judicial Council, shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and By-Laws.

Section 2. Number of Societies. Only one component medical society shall be chartered in any county but nothing in this section shall be construed as to prohibit unofficial organization of medical clubs or other county level groups of physicians whose purpose it is to further and advance scientific medicine and postgraduate medical education.

Section 3. Members of Societies. Each component society shall judge the qualifications of its own members, but as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered phy-

sician who is qualified under Chapter I, Section 1, of these By-Laws shall be eligible for election to membership. Before a charter is issued to any component society, full and ample opportunity shall be given to every such physician in the county to become a member.

Section 4. Right of Appeal. Any physician who may feel aggrieved by the action of the society of his county or District in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Judicial Council, which, upon a majority vote, may permit him to petition for membership in an adjacent society.

Section 5. Evidence of Appeals. In hearing appeals, the Judicial Council may admit oral or written evidence, as in its judgment will best and most fairly present the facts, but in case of every appeal, efforts at a conciliation and compromise shall precede all such hearings.

Section 6. Area Jurisdiction. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

Section 7. Professional Authority. Each component society shall have general direction of the affairs of the profession in its jurisdiction and shall constantly use its influence to the moral and professional betterment of its physicians, to the end that the membership shall embrace every qualified physician in its jurisdiction.

Section 8. Meetings. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall especially be encouraged to do postgraduate work, and to give the society first benefit of such labors. Official positions and other preferments shall be unstintingly given to such members.

Section 9. Delegates. Each county shall be entitled to representation in the House of Delegates of this Association, one delegate for each fifty members or fraction thereof. Delegates shall be elected for terms of not less than two years and societies shall report such elections to the Executive Secretary of the Association in no event later than thirty days before the annual session.

Section 10. Duties of Component Society Secretaries. The secretary of each component medical society shall perform such duties as are usual and customary to his office. He shall maintain the official roll of membership for his society, shall collect dues and assessments, and shall make official reports as elsewhere prescribed in these By-Laws to the Association, transmitting dues in behalf of component society members. He shall conduct the official correspondence of his component medical society.

## Chapter XIII FISCAL YEAR

The fiscal year of the Association and its component county societies shall begin January 1 each year and end on December 31 following, but membership in the state Association shall not lapse until April 1 of that year.

## Chapter XIV AMENDMENTS

These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, after the amendment has laid upon the table for one day.

## Chapter XV REPEALING AUTHORITY

Upon adoption of these By-Laws, all previous By-Laws, motions of record, mandates, policies, rules and regulations in conflict therewith are hereby repealed, except that officers elected to serve in the Association and its component societies shall continue their incumbency until the completion of their previously prescribed terms and their successors elected under the current By-Laws.



# Address of the President

CHARLES R. JENKINS, M.D.

Laurel, Mississippi

FOR SIX CONSECUTIVE years at as many annual sessions, the presidents of the Mississippi State Medical Association have addressed themselves to change:

—They have spoken of the emergence of third parties, the mushroom growth of the Blue Plans and private insurance in the post-World War II generation.

—They have noted that the public treasury is the successor to the private pocketbook when the bill is paid.

—They have warned that the quality of health services can and must be measured and that a use-benefit relationship is indispensable.

—And they have called on the practicing physician to assert his role as the leader, warning that he who ignores the challenge will not be a factor in the change.

This era of change spanning a generation is about ended, and I hope that we have profited from the intense scrutiny and timely comment given by these leaders. Although we see through a glass darkly, there is nothing very mysterious about the shape and substance of health care delivery in the last two decades of the 20th century.

It is clear enough that a single third party for the purchase of health services in the United States is less than a Congress away. In a sense, we physicians are assuring the certainty of this event with our Mediredit proposal. We can now give full validity to that catch-phrase of the 1950s: It is no longer a question of how the bill shall be paid—only one of who will do the paying.

But this question is only partially answered for us at the moment, and the half-unknown is a matter for the gravest concern.

—Will we have the full package, the total nationalization program, the reincarnation of Wagner-Murray-Dingell of the Truman era? I think not for a number of reasons, not the least of which is the absurd cost.

—Will we have a program centered around health care corporations, a sort of blueprint for Blue Cross survival? Perhaps we will.

—Will we have a quasi-private program, tied to health insurance with most Americans indentured to contract practice in HMOs? Perhaps we will.

—Will we have a health insurance-oriented program placed largely under the major financial institutions with government as a partner? Perhaps we will.

—Will we have a uniformly high standard, quality-assured program geared to ability to pay with government underwriting? Perhaps we will, and the prospects seem to be improving.

In any event, we can look for common features, no matter which direction the Congress chooses. Medicaid will come to an end, and in many states, its demise will be unlamented. We will see a catastrophic coverage feature aimed at taking bankruptcy out of illness. We will see uniformly rigid cost controls, and we will see careful management of quality.

As if there were some master timetable, the 92nd Congress provided the quality measure in Professional Standards Review Organizations.

The work of medicine in peer review and inquisitive innovation has not gone unrewarded, because we have the first shot at keeping the initiative. Without any question, this is the most urgent and massive challenge before us today.

The acceptable alternatives to a working, productive, results-oriented PSRO have been swept away. We need no longer flog that dead horse about doing this job or having it done for us.

Be assured that if we do not do this job, it will be done *to* us.

This, in essence, is the convincing case for fielding a maximum effort on PSRO. And in that connection, I have some good news and some bad news.

The good news is that American medicine got peer review into business with a seriousness which cannot be denied. With or without a single law on the books—past, present, or future—this effort can pay the greatest dividends in improved pa-

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President, Mississippi State Medical Association, 1972-1973.

Read before the House of Delegates, 105th Annual Session, Biloxi, April 30, 1973.

tient care since Lister decided that sepsis isn't good for us.

In the space of less than three years, American medicine managed to marshal some of the most productive, ingenious, and forward looking programs which have emerged from a profession or industry in recent times. It is true that we have certain incentives which generated unprecedented energies, but it is something which we should have done a generation ago.

The bad news is that our position in PSRO is much more tenuous than we would prefer. Initially, our emphasis was clearly on the economics of health care, and throughout American medicine, the early days of peer review were devoted to fees and costs. We may have been wise to have separated quality and costs, but this is now a moot point.

The statute as enacted is something less than mortgage-secured guarantee. More realistically, we are the parties giving the mortgage, for performance minimums will be unilaterally judged by government. And that, to compound the matter, is before the PSROs get a permanent job.

Despite crash effort, the massive program of AMA, the rash of meetings, and a growing liberal attitude toward getting into almost any acceptable medically oriented program, there is a distressing lack of uniformity in quality assessment methodology. Qualified staff is thin to nonexistent, depending on where you are. Physicians, hardly lacking for literature and information, still have much homework to do.

I am neither the devil's advocate nor a wet blanket. But I believe that this critically important aspect of the delivery mechanism ought not to be floated as an over-valued currency in an uncertain exchange market. Rather, we must get to work and fix a par, underwrite value, and demand fair exchange.

The ensuing months will try the metal and fabric of our Mississippi Foundation for Medical Care. Since the foundation is physicians, it needs us all and we need it. In fact, it will be foredoomed without most of us. But with us, it can be a pillar of strength in quality care delivery.

We must exercise caution in separating the foundation from any semblance of a union. It exists to deliver—never to impede—health services. The foundation is a warranty of the ethics we have proclaimed since the AMA was founded in 1847. It is a necessary addition to the house of medicine, and it fits almost perfectly into the design where the patient is paramount.

The foundation will not be completely divested

of all roles and prerogatives in care economics while shaping its programs around quality assessment. We will do well to remember that the worth of a product or service bears heavily upon cost and price and the willingness of the purchaser to enter the market. An honest product, honestly purveyed, is always in demand.

As we add to medicine's house with our medical care foundations, we cannot overlook some structural weaknesses which have developed in the past decade. If our component medical societies are the piers and beams, then the floors and walls are the state associations. If the AMA roof doesn't cover all of the structure, then we have an imperfect building, subject to leaks, inclement weather, the heat of a legislative summer, and the cold blasts of a third party winter.

Membership in all levels of organized medicine is second only in importance to the M.D. degree and a license to practice. As a postscript, let's keep in mind that the quality of the degree and the favorable licensure circumstances are largely achievements of the AMA. We owe it much.

## UNITY IN MEDICINE

As with Lincoln's house divided, medicine cannot stand without structural unity. These admonitions are unnecessary and inappropriate for a House of Delegates, but there is missionary work aplenty back home where many physicians are not members of their component medical society.

This business of quality and cost has its subsidiary aspects, too. In the New Federalism, the heavy hand on the national budget has not been loathe to fell a few sacred medical cows. There isn't much question about OEO and its many health programs. There are burning questions about Hill-Burton and the Regional Medical Programs. The National Institutes of Health, formerly unassailable as the fortress of science, are under siege. Comprehensive Health Planning is getting new life, and the role of HEW is a reassertion of the new and serious direction of the health of the nation.

We cannot stand on the perimeter merely looking at the action in the center. Where a former OEO health program moves into HEW, let us not be timid or reluctant to raise our voice in its implementation and management. As areawide planning councils are formed in Mississippi, make certain that component medical societies name physician-members.

There are implications with respect to continuing education in care quality assessment, and the day has long passed when we possess the organic capacity to conduct our own programs in medical organization.



This suggests the importance of the Regional Medical Program and our University Medical Center. The continued existence of the former is now in question, and the latter must expand its role with the practicing physician with or without RMP. But we are responsible for helping our university to make this possible. We can and must give new and added support to its growth and development.

The thin spread of our limited resources showed up in the recent session of the Mississippi Legislature where we won some, lost some, and had some rained out. The positive economy and austerity measures made necessary by membership and federal grant considerations have taken a toll. We will be tested in devising ways to augment our staff in numbers and talents. It is fair to say that there is not another medical association with our magnitude of programs and such a numerically limited executive staff.

There is other unfinished business in making sure that our association is tuned to the changing times. We are not, I believe, sufficiently responsive to the voice of the young physician, yet he is the majority. We could not very well survive the one-man, one-vote test, either, because our representation is notably misapportioned. We sometimes tend to cling to established leadership to the exclusion of systematic infusion of new and younger blood.

#### RECOMMENDATIONS

Accordingly, I would like to make the following recommendations to the House of Delegates:

(1) That the tenure of office of future members of the Board of Trustees be limited to two

three-year terms rather than three. The tenure of the present members of the Board would not be affected.

(2) That the President and the Speaker of the House be voting members of the Board of Trustees—this is in line with the AMA, American Academy of Family Physicians, and other national medical organizations.

(3) That the immediate Past President sit with the Board of Trustees—this to become effective in 1974. The immediate Past President is the one officer who by his extensive contacts the preceding year can best present to the Board the desires of the average association member.

(4) That an Ad Hoc committee of the House of Delegates be formed to study realignment of the nine association districts to more equitably divide the districts as to number of physician members—this committee to report back with concrete suggestions to the 1974 House of Delegates.

These are some—certainly not all—of our challenges. Better than that, they are also our opportunities. The end of an era, however traumatic, need not simultaneously signal the end of a cause. A *duty* of every profession is to carry the seed of its propagation; its *opportunity* is to carry the seed of its greatness.

Perhaps the veil of frustration, insecurity, vexation, and uncertainty results in too much pessimism. In union there is therapy for insecurity. In knowledge, there is remedy for uncertainty. In strength of purpose, there is banishment for vexation, and courage is the surety for it all.

If the new era cannot belong to us, better that we belong to the new era.

Let's get to work.

★★★

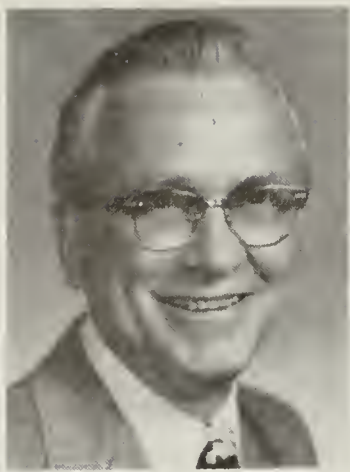
535 Fifth Avenue (39440)

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#### IRS SCORES AGAIN

After he filed his tax return, the assistant principal was called into the Internal Revenue office. There an auditor told him, "Sir, you listed two items that we find interesting. One is a \$500 contribution to Christian Science. The other is \$800 in doctors' bills."





# The President Speaking

## “Democracy in Medicine”

ARTHUR A. DERRICK, JR., M.D.

Durant, Mississippi

THE AMA MEETING was held recently in New York. At the convention the elected delegates from all the state societies convened to present, discuss, vote on and, perhaps even settle, some of the multiplicity of issues confronting our profession. The procedures followed the time-honored democratic process all the way from the “smoke-filled room” to the parliamentary dignity of the opening of the House of Delegates.

We, of all people, should be committed to the almost sacred precepts of the democratic concept, for it was here, as Macauley puts it, “in the depths of the American forests,” that this principle reached its apotheosis in this great country of ours. I freely admit Jefferson might have a little difficulty recognizing some of socialist-tainted concepts that have crept into our system, but we must remember all of these have been voted on by our freely-elected representatives, so the ultimate responsibility falls upon us, the electorate. In spite of the shifts in the winds and tides of errant politic we remain the great democracy, so, likewise, our association stands proud in the medical world, and so it must remain.

MSMA has long been blessed with a train of dedicated men of competence serving us as AMA delegates who have received and deserved the trust and confidence of their colleagues. In spite of the vociferations of the splinter groups, I deeply feel that right will out and that we are in good hands. ★★★



## Maternal Stilbestrol—Genital Adenocarcinoma—and Followup of Exposed Young Women

The Editors of the JOURNAL MSMA felt it appropriate and timely that full reproduction of this *Technical Bulletin* issued by the American College of Obstetricians and Gynecologists be published in this JOURNAL. Critical epidemiologic study has suggested that maternal exposure to stilbestrol or other related nonsteroidal estrogens has been of some etiologic significance in the development of clear-cell adenocarcinoma of the vagina and cervix in female offspring. The number of these cancers accumulated to date is small and the number of women treated during pregnancy with these compounds must be enormously large. Precise data is difficult to obtain inasmuch as a latent period of approximately 15-25 years seems to exist.

Similar cause-effect relationship is implicated in the development of vaginal adenosis in female offspring as well. There appeared to be many, many more cases of vaginal adenosis reported than clear-cell carcinoma, so that no one is in a position to say that adenosis is a bona fide precursor of the malignant process. The practical implications are quite straight-forward and simple. From the standpoint of the young patient, an awareness of these entities should be clearly kept in mind and appropriate gynecologic evaluation carried out if the patient is symptomatic. From the standpoint of both mother and female offspring, the physician who had utilized these preparations during pregnancy in any of his patients

should institute a course of followup so that the female offspring can be brought under critical surveillance. In so doing, appropriate reassurance is important. The association is not proved, but suspect. And the risk factor for serious problems appears to be very low. The authors of this *Technical Bulletin* have stated the case very succinctly. They have been involved with this interesting relationship from the start. For the interested reader, they have appended a helpful list of references. All Mississippi physicians should be aware of these newly described associations.

RICHARD C. BORONOW, M.D.

Department of Obstetrics and Gynecology  
University Medical Center

The recent association of clear-cell adenocarcinoma of the vagina and cervix in young women whose mothers were treated with stilbestrol during pregnancy has raised the problem of the approach that should be used to follow and examine these young exposed females. Most reported cases of these carcinomas have occurred in patients between 14 to 25 years of age. Stilbestrol, dienes-trol, and hexestrol, all nonsteroidal synthetic estrogens, have been implicated in the maternal histories of most of the cases investigated. The doses and duration of maternal hormone therapy have varied widely. As little as 1.5 mg stilbestrol daily taken throughout pregnancy and administration of the drug for as short an interval as 12 days during the first trimester have both been associated with



## EDITORIALS / Continued

tumor appearance in offspring. Occasionally negative histories have been encountered which suggest that other factors in addition to maternal hormone administration are operative in tumor formation.

It is not known how many women have been treated with stilbestrol or similar compounds during pregnancy in years past, but it is certainly many thousands. No accurate estimate can be given concerning the risk of tumor development in an exposed female. However, over 100 cases of clear-cell adenocarcinoma of the genital tract are known to have occurred in the past few years in young females and most have been associated with maternal hormone therapy. In view of the large number of women who were treated during pregnancy, and the relatively few cases reported thus far, the risk of development in any exposed female at the present time appears small.

These cancers have been detected in a few prepubertal girls, but most of the tumors have occurred in young women after the menarche. The tumors usually cause prolonged vaginal bleeding and staining or discharge. However, it is important to emphasize that asymptomatic cancers have been found on routine pelvic examinations, a few of which have been performed only because of a history of maternal stilbestrol ingestion. Although vaginal cytology can be useful for tumor detection, false negative results do occur and the vaginal smear test cannot be relied upon alone to detect the tumor. In addition, prolonged vaginal bleeding in young females can no longer be assumed to be due to anovulation and such young patients should receive a pelvic examination *whether or not* there is a definite history of maternal hormone ingestion. Cases have been encountered in which the presence of such abnormal bleeding has led to the diagnosis of tumor, and a positive history for maternal hormones was uncovered only after a diligent retrospective search was carried out subsequent to the patient being treated for carcinoma.

Because of the aforementioned considerations, we have recommended that all postmenarchal females whose mothers took stilbestrol or similar compounds during pregnancy have a complete pelvic examination, including vaginal cytology. If the child is younger when the gynecologist first becomes aware of the maternal history, some contact between the physician and the patient or her family should be maintained and certainly the patient should be thoroughly examined if any abnormal symptoms develop. An adequate examination includes a careful evaluation of the vagina

and cervix by inspection, palpation, Schiller-staining and biopsy of abnormal areas. Those areas that appeared red or fail to take Schiller stain are biopsied. Such examination can usually be easily carried out in the physician's office. Before the examination, the procedure as well as the reason for it are usually discussed with the patient and her mother. This usually helps the patient to relax, making the examination easier and less traumatic. After the smears have been taken for cytology, a speculum can be used to inspect the entire vagina, taking care that the blades do not obscure any lesion. A meticulous digital examination also aids in the detection of any early neoplasm. Occasionally, irregularity or roughening of the vaginal wall will be encountered providing a clue that the tumor may be present. A small speculum can be used for younger patients. If it is impossible to perform an adequate vaginal examination in an asymptomatic female at her initial office visit, she can be advised to use vaginal tampons for a few months and this will then usually allow an adequate examination to be performed without discomfort.

Although carcinomas will be infrequently uncovered by these screening examinations, our experience with a few patients suggests that vaginal adenosis, cervical erosion, and transverse vaginal and cervical ridges may be found in up to 30% of the exposed population. However, larger series have not yet been reported and no accurate estimate of the incidence of vaginal adenosis among these patients can be given at present. In addition, it should be noted that many patients whose mothers took stilbestrol during pregnancy appear to have normal vaginal and cervical examinations.

Patients whose first examination is normal are advised to have a return visit yearly. For those in whom any nonmalignant abnormality is found, more frequent follow-up is usually recommended. The natural history of stilbestrol-associated adenosis is unknown. Although adenosis has been found frequently in cases of vaginal carcinoma, we have not yet observed any direct histologic transitions from adenosis to cancer. Moreover, it is apparent from the previously cited figures that current evidence suggests there will be few cases of carcinoma in comparison to many cases of vaginal adenosis.

Prior to the advent of the use of stilbestrol during pregnancy, the few cases of adenosis reported were treated by surgical extirpation, cauterization or observation, and occasionally spontaneous regression has been reported. Vaginal adenosis may be multicentric and thus the removal of one focus cannot guarantee its total eradication. It would



seem reasonable to treat lesions that are symptomatic or those that have been associated with nuclear atypicality by local destruction or excision. It may be necessary to use a skin graft in cases where surgical therapy results in the excision of a large segment of the vagina. Close observation is certainly necessary and in many cases might prove to be the most prudent approach to be followed in cases of vaginal adenosis.

*It is undoubtedly wise in instances where records are available to notify patients who have been treated with stilbestrol during pregnancy so that their daughters can be examined.* In many cases this is not possible due to the lack of documentation of medicines that were prescribed 10 to 25 years ago. However, the mothers can at present be assured that the risk of tumor development in any exposed female appears to be low.

It is important that these women and their daughters realize that a regular vaginal examination should be performed in females who have been exposed to stilbestrol *in utero*. In most instances both the patient and the parents can discuss these problems candidly with the physician without raising undue concern. At present there is no evidence to indicate that males have been affected by intrauterine stilbestrol exposure.

The rare occurrence of these malignancies suggests that the experience of any one clinic with this tumor will be small. Therefore a Registry of Clear-Cell Adenocarcinoma of the Genital Tract in Young Females has been established. Supported by grants from the National Institutes of Health and the American Cancer Society, the Registry is centralizing information and evaluating data to study pathogenesis, maternal histories and therapy in cases of cancer occurring in the United States and abroad. All cases of clear-cell adenocarcinoma of the genital tract occurring in women under the age of 30 years are being considered, *whether or not* there is a history of maternal hormone ingestion. All information is kept strictly confidential and the Registry is interested in acquiring information about all such cases whether or not they have been published or are going to be published by the physicians or institutions responsible for the patient care.

Communications should be addressed to:

Arthur L. Herbst, M.D., Director, or  
Robert E. Scully, M.D., Pathologist  
Registry of Clear-Cell Adenocarcinoma of  
the Genital Tract in Young Females  
Warren 275  
275 Charles Street  
Boston, Mass. 02114

Preliminary results from the Registry have

shown that the tumors can occur in the cervix as well as the vagina. Patients thus far reported are 8 to 25 years of age at the time of diagnosis and have been born throughout the United States as well as in 3 foreign countries. Detailed follow-up information is available at present in 65 cases. Seventeen of these have died or developed recurrence in spite of the fact that follow-up in many instances is less than 2 years. Although these cancers are rare, they can behave in a virulent fashion. The frequency of asymptomatic cases as well as the unreliability of vaginal cytology for detection support the value of screening postmenarchal females who have been exposed prenatally to stilbestrol or similar drugs.

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## LETTERS

SIRS: Again, this year I am compiling case reports of allergic reactions to biting insects, i.e., mosquitos, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, etc. I am also interested in reactions to the Imported and Southern Fire Ants.

I would like physicians to supply me with case reports of those patients who have had reactions to such insects. Please include in the reports the type of reaction and the complications, if any, the age, sex, and race of the patient, the site of the bites, the season of the year, the immediate symptoms, the skin test results, desensitization results, if any, and any associated other allergies. Send this information to me at the following address:

CLAUDE A. FRAZIER, M.D.  
4-C Doctor's Park  
Asheville, NC 28801.

SIRS: With the arrival of hot weather we expect that Rocky Mountain Spotted Fever (RMSF) will be occurring again this year in Mississippi. Last year there were 13 reported cases in the state with two deaths. Tennessee and Arkansas had many more reported cases with additional deaths. In order to study this problem further, the Division of Preventable Disease Control in cooperation with three entomologists from Mississippi State University will be collecting ticks from various recreational areas throughout the state and determining their rate of infection with rickettsiae or rickettsial-like organisms by staining their hemolymph. We would like your assistance in alerting us to any *suspected* cases of RMSF you might encounter. The Public Health Laboratory will be able to offer free complement fixation titers for a battery of Rickettsial antigens including *R. rickettsii* (the etiologic agent of RMSF), *R. canada*, *Q. Fever*, and the typhus group. In addition, titers for Proteus OX2 and OX19 (the Weil-Felix Reaction) are available free of charge through the Public Health Laboratory.

We are urging that paired sera be obtained for rickettsial titers. We will be happy to provide information of the presence or absence of rickettsial-like organisms in any ticks found on the person of suspected cases or on their pets. Collected ticks should be stored in a glass jar with a perforated lid. Ticks can be stored in such containers for months without food or water.

Please call Dr. Daniel J. Sexton at 354-6650 (day) or 956-6934 (night) for any further information or to report suspected cases. Collect calls will be accepted during the day.

### ROCKY MOUNTAIN SPOTTED FEVER

Identification: This prototype disease of the spotted fever group is characterized by sudden onset, with fever which ordinarily persists for two to three weeks, headache, chills, and conjunctival infection. A maculopapular rash, appearing on the extremities about the third day, soon includes the palms and soles and spreads rapidly to most of the body; petechiae and hemorrhages are common. Fatality is about 20 per cent in the absence of specific therapy; death is uncommon with prompt treatment. Synonyms: New World Spotted fever, Tick-borne typhus fever.

Occurrence: Throughout most of the United States, during spring and summer. Most prevalent in South Atlantic states—less prevalent in Rocky Mountain region. Commonest in wooded suburban areas of the Piedmont Plateau. In western United States adult males are attacked most frequently, children in the East; the difference in infection relates to varied exposure to infected ticks. Fatality increases with age.

The infectious agent is *Rickettsia rickettsii*.

Reservoir: Infection in nature is maintained by transovarian and transstadial passage in ticks. The organisms can be transmitted to various rodents and other animals, which assists in maintaining the disease cycle.

Mode of transmission: Ordinarily by bite of an infected tick with several hours of attachment to allow "reactivation"; also contamination of skin with crushed tissues or feces of tick. In eastern and southern United States the common vector is the dog tick, *Dermacentor variabilis*; in northwestern United States, wood tick, *Dermacentor andersonii*; in southwestern United States, occasionally the Lone Star tick, *Amblyomma americanum*. The rabbit tick *Haemaphysalis leporis-palustris* is infected in nature but usually does not bite man. Three of these ticks are known to occur in Mississippi.

The incubation period is from three to about 10 days.

Period of communicability: Not directly transmitted from man to man. The tick remains infective for life, commonly as long as 18 months.

Susceptibility and resistance: Susceptibility is general. One attack probably confers immunity.

Laboratory diagnosis: Complement fixation tests using group-specific spotted fever antigens become positive in the second week; the Weil-



Felix Reactions with Proteus OX19 and Proteus OX2 become positive less often.

Treatment: The tetracycline antibiotics or chloramphenicol in daily oral doses until patient is afebrile (usually three days) and for one or two additional days.

Preventive measures: (1) Avoid tick-infested areas when feasible; remove ticks from the person promptly and carefully without crushing; protect hands when removing ticks from animals. Tick repellents of value are N, N-diethyl-m-toluamide and dimethylphthalate. (2) Measures designed to reduce tick populations are generally impractical. (3) Education of the public in mode of transmission by ticks and the means for personal protection.

DANIEL J. SEXTON, M.D.  
Medical Epidemiologist  
State Board of Health  
Jackson, Miss.

Source: Beneson, A. S.: *Control of Communicable Diseases in Man*. APHA. 1970.

## HMO Sourcebook Is Published

Publication of the *HMO Sourcebook*, a special edition of a continuing study of state laws affecting the prepayment of medical care, group practice and HMOs, has been announced by the Health Law Center, Aspen Systems Corporation.

The study is the reference source on HMOs for the U. S. Department of Health, Education, and Welfare and the 400-page special edition of this study, the *HMO Sourcebook*, has been prepared for health professionals, with HEW permission.

The reference work is invaluable for health professionals interested in forming or operating a group practice or HMO, affiliating with or using such an organization, or gauging the possible threat to present fee-for-service organizations.

Those statutes, rulings, attorney general opinions, case laws, and legislative intentions, which make up the general legal climate in each state and which tend to block or facilitate the establishment of pre-paid medical care, are reviewed in the sourcebook in clear and concise language.


The sourcebook points out that only Florida and Tennessee have enacted specific HMO enabling legislation. In other states, the HMO may be formed under other enabling legislation such as those providing for the formation of a medical service corporation, a professional corporation, or domestic mutual insurers. In most states, however, it has been found that existing regulations are inappropriate for the formation and operation of HMOs.

The obstacles or drawbacks to the formation of HMOs, therefore, depend on the legal climate in each state, and the *HMO Sourcebook* enables the health professional and his attorney to better evaluate present and future prospects in each state for HMOs and pre-paid group practice organizations.

Copies of the *HMO Sourcebook* may be obtained for \$24.75 by writing to Dept. RR, The Health Law Center, Aspen Systems Corporation, 11600 Nebel St., Rockville, Md. 20852.



### DEATHS

 GUINN, ELIAS K. (E-RET), Okolona. M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1909; interned Charity Hospital, Nashville, Tenn., one year; member of Fifty Year Club of MSMA; Emeritus member of MSMA and AMA; died May 16, 1973, age 92.

HOLLAND, WILLIAM C., JR., Jackson. Born in Alabama in 1922; M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1948; post-graduate work in physical chemistry at Vanderbilt and Oxford University; died May 22, 1973, age 51.



### NEW MEMBERS

DYAS, EDMUND C., IV, Hattiesburg. Born Mobile, Ala., Nov. 11, 1939; M.D., Tulane University School of Medicine, New Orleans, La., 1965; interned Charity Hospital, New Orleans, La., one year; orthopaedic residency, Duke University, Durham, N. C., 1966-1970; elected by South Mississippi Medical Society.



## PERSONALS

O. J. ANDY of Jackson and UMC attended a symposium on quantitative brain research in Indianapolis.

HELEN C. BERNFIELD of Jackson served as co-chairman of the 49th annual convention of the Mississippi Federation of Business and Professional Women's Clubs. Dr. Bernfield is current president of the Capitol BPW Club.

RICHARD C. BORONOW of Jackson and UMC gave a presentation at the American College of Obstetricians and Gynecologists conference in Bal Harbour, Fla. HENRY THIEDE, UMC department chairman, also attended the ACOG meeting.

ALFRED W. BRANN, JR., of Jackson and UMC attended the regional Congress on the Quality of Life held in New Orleans in May.

JOEL T. CALLAHAN of Meridian has been elected medical advisor to the Lauderdale County Unit, American Cancer Society.

WILLIAM R. CLEMENT of Gulfport announces the relocation of his office for the practice of dermatology to 0450 Pass Road.

MAGRUDER CORBAN of Gulfport has been elected chairman of the Mississippi Gulf Coast Health Resources Council.

MILLARD S. COSTILOW of North Carrollton was elected chairman of the Steering Committee of the North Central Mississippi Health Planning Council. ALFIO RAUSA of Greenwood is serving as secretary.

L. STACY DAVIDSON of Cleveland and DAYTON E. WHITES of Lucedale have been appointed to serve on the General Alumni and Medical Alumni Boards of Directors of the Ole Miss Alumni Association. They will serve three year terms.

ARTHUR A. DERRICK, JR., of Durant, MSMA president, was guest speaker at a banquet for retiring Holmes Junior College faculty.

JOHN Y. GIBSON of Jackson and UMC took a course in cardiac radiology at Albert Einstein College of Medicine in New York in May.

JERRY GULLEDGE of Crystal Springs was a candidate for the office of alderman of the city of Crystal Springs.

JAMES D. HARDY and HERBERT G. LANGFORD of Jackson and UMC both spoke at the New Orleans symposium sponsored jointly by the Mississippi, Louisiana and Arkansas heart associations.

SAMUEL B. JOHNSON of Jackson was named president-elect of the Louisiana-Mississippi Ophthalmological and Otolaryngological Society at the group's annual meeting in Biloxi.

TRAVIS E. LUNCEFORD and Mrs. Lunceford of Maben were honored by a surprise reception and "This Is Your Life" program at the Maben First Baptist Church in recognition of Dr. Lunceford's 16 years of service to the community. Dr. Lunceford is moving to Waco, Tex., to become associated with Baylor University.

A. F. MOSS and VICTOR H. APPLEWHITE announce their association in the practice of medicine and surgery at Ellisville Municipal Hospital in Ellisville.

W. T. OAKES of Amory was re-elected state advisor at the seventh annual convention of the American Association of Medical Assistants, Mississippi chapter.

MARIO R. PINEDA announces the opening of his office for the practice of psychiatry at Suite 301, Medical Tower, 440 East Woodrow Wilson in Jackson.

JOSEPH A. PRYOR of Tupelo and THOMAS L. PURVIS, JR., of Natchez were installed as Fellows of the American College of Obstetricians and Gynecologists at its 21st annual meeting in Miami Beach.

ROBERT M. RITTER of Whitfield has been appointed to the staff of the Jackson Mental Health Center. Dr. Ritter will be involved in educational and training programs with the inpatient element of service being his primary responsibility.

G. BOYD SHAW of Jackson has been elected chairman of the Hinds-Madison-Rankin chapter of the Mississippi Lung Association. Others elected to the advisory board are WALTER TREADWELL and J. L. WOFFORD of Jackson and CURTIS ROBERTS of Pearl. GEORGE RILEY of Jackson was re-elected as an honorary member.

GEORGE V. SMITH and JOHN BOWER of Jackson and UMC attended sessions of the Southeastern Organ Procurement Foundation in Richmond, Va.





### Book Reviews

**Newer Anticancer Drugs and Procedures.** Edited by M. Fiorentino. 150 pages with illustrations. Padova, Italy: Piccin Medical Books, 1971.

The jacket of this little book concisely describes its contents:

"This book reports the Proceedings of a seminar held in Padova.

"Italian physicians involved in the clinical fight against cancer presented here for the first time new drugs such as Peptichemio; French and English contributors also participated to give a clear definition of the clinical exploitability of Adriamycin, Merophan, Bleomycin, Mithramycin and of their side effects and the means of preventing dangerous toxicity from BCNU and Adriamycin."

The physician who is involved in treating cancer with drugs is faced with a series of decisions to be made on every case. First, there is a choice of the appropriate drug or combination of drugs and then the selection of the proper dosage and best schedule of administration. Subsequently, the patient's response must be evaluated and decisions need to be made regarding adjustment of drug dosages or schedules or changes in the entire plan of treatment. The knowledge and judgment for making these decisions in many cases must be gained by experience or simply by trial and error. Responsible physicians are always glad to widen their experience by taking into account the experience of others who have explored their same fields of endeavor. For this reason, this volume might be of benefit to physicians concerned with and experienced in the field of chemotherapy. It certainly is not a primer for the novice chemotherapist, but it does present informally and in very readable fashion some of the results obtained by the participating contributors. Essentially, these are primarily phase I type studies in which drugs are simply being tried in a variety of patients to evaluate their possible effectiveness in treating different types of tumors. None of these studies present controlled comparisons between different drugs or schedules of treatments. Therefore, no definitive answers can

be derived from these data but the results can be integrated into one's own experience.

It appears fairly obvious that the rather strict regulations pertaining to the use of experimental or developmental drugs in the U.S.A. do not have their counterparts in European countries. The rather loosely constructed, uncontrolled clinical experiments described in these papers obviously would not be permitted by physicians in similar types of practices in the U.S.A.

In summary, this little volume might be of some interest as an additional reference book for experienced chemotherapists but should not be considered as a guide to the use of these very potent drugs by those inexperienced in their use.

GUY T. GILLESPIE, JR., M.D., Jackson, Miss.

**The Lymphatic System.** By Mario Battennati, M.D., and Ippolito Donini, M.D. 496 pages with illustrations. Padua and London: Piccin Medical Books, 1972. \$30.00.

This book represents a decade of work by the authors and is an attempt to pull together all that is known about the lymphatic system which they describe as "a factor of vital importance to the general economy of the body." They propose to describe and discuss in detail the anatomy, physiology and physio-pathology of the lymphatic system, present a systematic description of pathology, and stress the biology of lymphoid tissue of significance to immunology of tissue transplant.

These are, of course, very ambitious objectives, and the authors admit failure to achieve perfection. It is this reviewer's opinion that failure to reach perfection is a rather euphemistic description of the effort. Out of 500 pages, less than one page is devoted to the lymphocyte. I would suggest that discussion of the biology of lymphoid tissue would require many times that space even if only a glimpse of the essential physiology is to be presented. "Immune function and the thymus" gets only three pages. There is only one reference to the work of R. A. Good and that a 1962 publication. Pathology of the lymph nodes is discussed in twenty-odd pages, and the "systematic description" breaks down into inflammatory conditions, systemic tumoral conditions, lymph nodal metastases, and effects of irradiation. Tumoral conditions refer to leukemia and sarcomas, as

well as granulomatous disease including Hodgkins Disease. There is no reference to Lukes and Butler and their modern classification in Hodgkins Disease. Non-Hodgkins lymphoma is also not classified.

What can be said for the book is obviously its *raison d'être*. From page 269 to 412 is a description of the lymph drainage of all major organ systems. This is based on the authors' extensive work with injections of radiopaque dyes. There are numerous color plates as well as x-ray photographic reproductions. The paper is excellent, and the print and illustrations are good. The result of all of this, however, does not add to what is available in standard anatomic or surgical texts and, in my judgment, would not warrant the price of the book.

FRANCIS S. MORRISON, M.D., Jackson, Miss.

## Region 12 MH-MR Program Planned

According to a new newsletter issued by the Region 12 MH/MR Commission, the region is closer than ever to having much needed mental health and mental retardation services. The region includes Jeff Davis, Covington, Jones, Wayne, Marion, Lamar, Forrest, Perry and Greene counties. The regional commission has given final approval to a proposal for services in the region. The planned program will be presented soon to boards of supervisors of all counties in the region with a request for funding.

According to Dr. David S. Hargrove, who has coordinated the planning and will direct the new program, "Recent cutbacks in federal funding of mental health programs mean that the communities of Region 12 must support the program if it's to operate. This can become an advantage for it will necessitate more community involvement and may strengthen the program in the long run." The Region 12 planning currently is conducted with a one-year grant from the National Institute of Mental Health and with funds provided by several of the county boards.

A major characteristic of the proposed program is its decentralization. Center headquarters will be in the larger communities of Hattiesburg and Laurel, but the smaller service centers proposed for every county seat town will make it possible for the people of the region to receive services in their home counties.

# Rondomycin<sup>®</sup> (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** **Gastrointestinal** (oral and parenteral forms), anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. **Gonorrhea** In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



WALLACE PHARMACEUTICALS  
CRANBURY, NEW JERSEY 08512



## Dr. J. C. Longest Appointed to NICSH Board

Dr. John C. Longest, director of the Student Health Service at Mississippi State University at Starkville, has been appointed the American College Health Association's representative to the board of directors of the National Interagency Council on Smoking and Health.

The National Interagency Council on Smoking and Health is a voluntary association of 34 health, education and youth leadership organizations vitally concerned with the problem of cigarette smoking and its effects on human health. It seeks to be a cooperative and independent force to inform the public regarding the harmful effects of tobacco use, especially cigarette smoking.

The council joins the resources and energies of its many member organizations in behalf of a single national goal. As a cooperative body it avoids duplication, serves as a medium for the exchange of information, and provides a mechanism for stimulating new programs and for evaluating existing programs on smoking and health.

Dr. Longest is currently serving as chairman of the MSMA Committee on College Health. He received his M.D. degree from LSU School of Medicine and completed internship at Southern Baptist Hospital in New Orleans.

He is a member of MSMA, AMA, American and Mississippi Academies of Family Practice, American and Mississippi heart associations, American Cancer Society, Mississippi Thoracic Society and New Orleans Graduate Medical Assembly.

## Coast Center Plans Drug Abuse Program

A \$50,000 grant, for a one-year period, has been made to the Gulf Coast Mental Health Center for initiation and development of a drug abuse program. The objectives of the project are to provide a measure of the extent, frequency and nature of drug abuse in the region's four counties—Harrison, Hancock, Pearl River and Stone—and to design a comprehensive community drug abuse service project.

Information which is gathered will be used to involve the community in the planning, design and implementation of needed drug abuse services. The planning project is being coordinated by Leonard Bruce Phillips of the center staff.

## Dr. Gronvall Is Honors Day Speaker



*Dr. John Gronvall, center, former University of Mississippi Medical Center associate director and School of Medicine associate dean, was keynote speaker at Honors Day and the Alpha Omega Alpha initiation banquet in May. Dr. Gronvall is currently University of Michigan medical school dean and medical center director. Here he talks with UMC director and School of Medicine dean Dr. Robert E. Blount, left, and Steve Hindman, right, medical school senior who received both the \$1,000 Pfizer Scholarship at Honors Day and the Leathers Award at Commencement as top medical graduate.*

## Medicolegal Forms Booklet Is Available

A new and expanded edition of the booklet "Medicolegal Forms with Legal Analysis" is now available. The booklet has been prepared by the office of the General Counsel of the American Medical Association.

The new edition has been expanded to 119 pages. The earlier edition contained 49 pages. The new booklet contains an updated and brief discussion of the various areas of medical law and suggested consent forms.

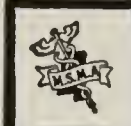
The booklet is available at a cost of \$1.00 per copy or \$.75 per copy if 11 or more are ordered for delivery to a single address. Orders should be directed to the AMA Order Department, 535 N. Dearborn St., Chicago, Ill. 60610. Refer to OP-109 when ordering.



**Because you  
practice  
medicine in the  
Magnolia State...**







# Dr. Norman C. Nelson Becomes New Dean of the University Medical Center

Dr. Norman C. Nelson will become vice chancellor for health affairs and dean of the medical school at the University of Mississippi Medical Center in Jackson July 15.



*Dr. Nelson*

Dean at LSU School of Medicine in New Orleans since 1971, the 43-year-old surgeon has been on the faculty there for 10 years, rising from instructor to professor of surgery, becoming associate dean in 1969, and dean two years later.

University Chancellor Porter L. Fortune, Jr., said, "Dr. Nelson's experience as practicing surgeon, superior teacher, and successful administrator gives him the solid background the Medical Center's chief administrative officer must have. He has the proven ability and leadership quality vital to the academic health sciences, particularly in 1973 when changes in federal priorities have put all university health centers under severe financial stress."

The new appointee succeeds Dr. Robert E. Blount, Medical Center director and medical school dean, who reaches retirement age in July.

The change in title from director to vice chancellor reflects the increased and broadened responsibilities accompanying Medical Center growth, Chancellor Fortune explained. The size and complexity of the Medical Center, with its established Schools of Medicine, Nursing, and Health Related Professions, and developing dental school, University Hospital, graduate study, research, and community service programs call for a different administrative structure than was needed previously, he said.

Dr. Nelson got his medical and undergraduate

degrees at Tulane University and did his internship and residency at Charity Hospital of Louisiana prior to a year as a clinical and research fellow in surgery at Harvard.

Dr. Nelson's special recognitions include election to Omicron Delta Kappa, leadership fraternity, Phi Kappa Phi, Sigma Xi, and Alpha Omega Alpha, honor societies.

His academic career is marked by five years as a Markle Scholar, a Southern Surgical Association Shipley Award, five consecutive years' recognition as best clinical lecturer at LSU, designation as most inspirational teacher in 1966 and 1968, and Class of 1970 selection as outstanding teacher.

He holds membership in 20 professional societies including the Association of American Medical Colleges, American Association for the Advancement of Science, American Medical Association, Society of University Surgeons, and the Association for Academic Surgeons. He is a fellow of the American College of Surgeons and the Southeastern Surgical Congress and is current president of the Surgical Association of Louisiana.

Among Dr. Nelson's numerous activities are past-chairmanship of the American College of Surgeons Region 7 Commission on Cancer, consultant in surgery to the USPHS Hospital in New Orleans, service on the board of the Louisiana Division, American Cancer Society, the medical professions advisory subcommittee of the Health Education Authority of Louisiana, the Regional Advisory Group of the Louisiana Regional Medical Program and chairmanship of the committee on health manpower of the New Orleans Area Health Planning Council.

Dr. Nelson was born in Hibbing, Minn., in 1929. In his early childhood, his family moved to Vicksburg where his father owned and managed the National Park Hotel, later to Biloxi and Houston, Texas.

## Five Added to Medical Center Faculty

The Board of Trustees, Institutions of Higher Learning, named five full-time faculty members to the teaching staff of The University of Mississippi School of Medicine in May.

Dr. James Edward Keeton, surgery (urology) assistant professor, holds the B.A. and M.D. degrees from The University of Mississippi. He interned at University Hospital in Jackson. A former postgraduate trainee at Middlesex Hospital in London, England, Dr. Keeton was a medical officer at Great Lakes Training Station in Illinois prior to his appointment.

Dr. Krishnarao Potnis, assistant professor of obstetrics and gynecology, returns to the Mississippi faculty following a nine-month stay as private practitioner in his native Bombay, India.

Medicine assistant professor Dr. Tate Thigpen, a University of Mississippi graduate and School of Medicine graduate, interned at Strong Memorial Hospital in Rochester, N. Y., and did his residency at University Hospital in Jackson, where he was also a hematology fellow.

Dr. Ronald Ross Watson is assistant professor of microbiology. He holds the B.S. degree from Brigham Young University and the Ph.D. from Michigan State University. His post before coming to Mississippi was assistant professor at Harvard.

Dr. Hardy Woodbridge, former clinical instructor in medicine (family practice), is now on the full-time faculty as assistant professor of family medicine.

In other faculty changes, Dr. Walter Treadwell, medicine assistant professor and inhalation therapy director, has been named acting chairman of the new department of family medicine.

## New Family Practice Residencies Approved

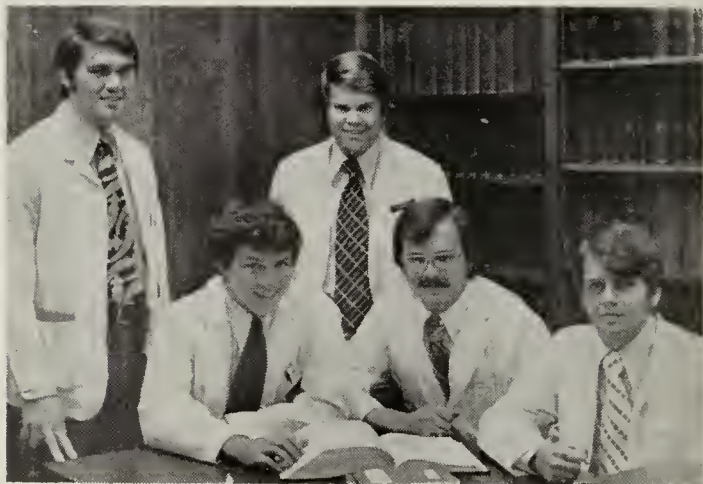
Fifteen new family practice residencies have been approved by the Residency Review Committee for Family Practice, bringing the total number of training programs in the new specialty to 164.

Currently there are 1,053 residents in family

practice training. The American Academy of Family Physicians, the American Board of Family Practice, and the American Medical Association are represented on the Residency Review Committee, which meets periodically to examine programs for approval.

The new programs are: University of Alabama, Huntsville Hospital Family Practice Center, Huntsville; Middlesex Memorial Hospital, Middletown, Conn.; University of Florida, Alachua General Hospital, Gainesville; Medical College of Georgia, Augusta; Doctors Memorial Hospital, Carbondale, Ill.; St. Elizabeth Hospital, Covington, Ky.; Montefiore Hospital and Medical Center, Bronx, N. Y.; State University-Kings County Hospital Center, Bronx, N. Y.; McKeesport Hospital, McKeesport, Pa.; Naval Hospital, Charleston, S. C.; Sioux Valley Hospital and McKennan Hospital, Sioux Falls, S.D.; Memorial Medical Center, Corpus Christi, Tex.; Lutheran General Hospital, San Antonio, Tex.; Family Medicine Spokane, Spokane, Wash., and St. Mary's Hospital, Milwaukee, Wis.

## MECO Summer Project Gets Underway



*The Medical Education-Community Orientation (MECO) project is placing over 40 medical students in 30 local hospitals throughout the state for 10-week summer stints. University of Mississippi School of Medicine students heading the Student American Medical Association program are, from left, junior Doug Rouse of Hattiesburg, Mississippi SAMA chapter past-president; sophomore Bob Flowers of Brookhaven, new state MECO director; senior Tom Greer of Anguilla, national MECO director; junior David Irwin of Saltillo, SAMA state past vice-president and state MECO summer director, and sophomore Robert Herrington of Ocean Springs, state SAMA president for the coming year.*



## ACS to Meet In Chicago

The world's largest meeting of surgeons, the 59th annual Clinical Congress of the American College of Surgeons, will be held in Chicago, Oct. 15-19. More than 15,000 doctors and guests from throughout the world are expected to attend. Official headquarters will be the Conrad Hilton Hotel, with sessions at McCormick Place and several area hotels.

Fellows of the College whose dues are paid to Dec. 1972 may register free. Initiates, members of the Candidate Group and surgical residents register free. Non-Fellows pay \$90, non-Fellow doctors in the federal services pay \$50. *Everyone* taking one of the 16 postgraduate courses must pay the fee for the course selected.

The Clinical Congress of the American College of Surgeons is open to all doctors of medicine. Official forms for registration, housing and postgraduate courses may be obtained from Fred Spillman, Convention Manager, American College of Surgeons, 55 E. Erie Street, Chicago, Ill. 60611, phone (312) 664-4050.

Dr. Edwin W. Gerrish, assistant director, is in charge of all scientific programs for the College.

## Delta Center Studies Disabilities Program

Dr. Gilbert Macvaugh, Jr., director of the Delta MH-MR program, has announced plans to study needs in that region for a day-training program to serve pre-school children with developmental disabilities and to assist their families to give these children better care at home.

If a community survey, now being conducted, identifies enough of these children to warrant a need for this program, initial plans are to begin the day training program in September, with about 12 children attending in the morning and 12 in the afternoon. The proposed program would promote personal and social adjustment. Perceptual motor training and communication skills and academic readiness would be stressed.

An advisory council subcommittee has been formed to assist the center with planning for the proposed handicapped child program. Mrs. Mary Alice Cates is chairman.

## Gender Identity Change In Transsexual Reported

The first known case of successful change of gender identity in a confirmed transsexual was reported in the April issue of *Archives of General Psychiatry*, a publication of the American Medical Association.

The case involved a 17-year-old boy who had grown up acting like a girl to such an extreme that he had dropped out of school because of teasing by his classmates, and was unable to function in his true physical role of a male.

The youth was seriously considering seeking a sex-change operation, in which the male organs would be removed and replaced surgically by an outward semblance of female sexual organs, when a team of therapists from the Department of Psychiatry of the University of Mississippi Medical Center took charge of the case.

At the beginning of treatment, the youth sat, stood, walked and talked like a girl. His patterns of sexual arousal and sexual fantasies were those of a girl. He liked to wear feminine clothing. His behavior was extremely effeminate.

The female behavior components were analyzed and defined, and, through lengthy psychotherapy, were gradually modified, piece by piece. The boy was taught to sit, stand and walk like a man. He was helped to cultivate a masculine voice; a masculine social behavior was taught. Male sexual fantasies were initiated and strengthened.

Finally a change in pattern of sexual arousal from homosexual to heterosexual was induced successfully.

"The gender role may not be as inflexible as assumed," declared the therapy team at the conclusion of their work.

Heretofore, only sex-change surgery had offered any hope to the transsexual. Psychotherapy had not worked. In this case, a year after treatment the patient was back in school, doing well, had a steady girl friend and was in all respects functioning in his true physical role as a male. The treatment was carried out over a period of a year, and the patient was rechecked regularly during the year following.

Authors of the report are David H. Barlow, Ph.D., E. Joyce Reynolds, and W. Stewart Agras, M.D., all of Jackson, Miss.

## ORGANIZATION / Continued

# JAMA Editorial Stresses Operating Room Safety

A plea for greater care in checking electrical devices in hospital operating rooms is voiced in an editorial in the May 28 issue of the *Journal of the American Medical Association*.

"The life-saving results achieved by a team of skillful surgeons and anesthesiologists, reinforced by a well-trained team of nurses and operating room personnel, may be nullified by a simple and avoidable accident of a mechanical or electrical nature in the operating room," the editorial says. The author is Dr. Zenonas Danilevicius, a senior editor of the *Journal*.

"The most difficult and invisible dangers to the patient lurk in the electrical system of the operating room, in its electrical and electronic equipment."

The hazard of static electricity is well known, and is universally avoided by use of materials, clothing, equipment, shoes and flooring material that do not conduct electricity.

A danger arises with the use of high-powered electrical equipment, especially for electrosurgery or electrocautery, the editorial reports. Cited is a situation in one hospital in which nine patients suffered burns at the sites of electrocardioscope electrodes (heart monitoring equipment) within a period of 10 months.

Causes of the burns were broken ground wires, defective rectifiers, improper equipment, improper use of active electrodes, capacitive coupling of cables, and radio frequency current division. The staff made a detailed study of the electrical system and the defects were corrected.

One case is indicative of the problems sometimes encountered. During surgery the electrocardiographic tracing did not function properly and the electrical connection was transferred from one wall plug to another. The anesthesiologist felt a shock in the hand in checking the patient's pulse, the patient made a sudden jerking movement and the pulse stopped abruptly. The doctor immediately pulled out the plug and began first aid. The patient made a full recovery. A follow-up investigation revealed that an improperly wired electrocardiographic monitor had been in use for some time. Also some of the wall sockets in the operating room had reversed polarity. All defects were immediately corrected.

"Isolated power systems are highly recommended for the patient-care areas in all hospitals. The isolation transformers and the line-isolation

monitors are also recommended as a protection against macroshock hazards. Proper grounding of all the equipment and of all the electrical systems is also a must. Frequent checks of all electrical aspects of the operating rooms by skilled engineer-surgeon teams would be a good measure of protection."

## Weems Center DDP Grant Will Assist

E. G. McLean, executive director of the Weems Community Mental Health Center at Meridian, says a recent \$18,750 Developmental Disabilities Program grant from the Interagency Commission "will allow the center to proceed with an in-depth study into the problems of the mentally retarded, to identify existing sources of aid both public and private, and will result in recommendations regarding additional services and programs needed to assist this segment of our population."

The study, which began in April, is being conducted by center staffers, with the support of other professional personnel from area agencies.

## Dr. Mora Receives UMC AOA Award



Dr. Lidio O. Mora, right, University of Mississippi School of Medicine medicine associate professor and chief of gastroenterology, received a plaque from the University chapter of Alpha Omega Alpha national medical honorary for his years of service to the Jackson medical community as both clinician and dedicated teacher. Dr. Mora leaves Mississippi in July to practice in Miami, Fla. AOA member J. Thomas Balzli, medical school senior, center, makes the presentation while medicine chairman Dr. Harper Hellems congratulates Dr. Mora.



uld be an obligation of medical  
ctice...

"Medical societies ought to con-  
t continuing campaigns to point  
the substantial savings that could  
realized thru deductible insurance  
l protection for catastrophic ill-  
s. At the very least, they should, in  
patients' interest, question the  
tics of any insurance organization  
t raises health care costs by forc-  
policyholders to buy insurance  
y may not need or want and prob-  
y won't ever use.

"Too many doctors are indiffer-  
t to the economic consequences of  
eir decisions. Too many, for ex-  
ple, habitually hospitalize patients  
the convenience of the MD. It's  
nsense to deny such habits exist...

"Doctors, thru their medical so-  
eties, have unhesitatingly appealed  
their patients for support in the  
ght against government interference  
th the private practice of medicine.  
nd the public in the past has re-  
onded. It's time the American Med-  
al Association and state and local  
medical societies paid off the debt by  
ecisive action to hold down the cost  
f medical care."

#### Cost of Drugs

Insurance rates and hospital  
charges are only two factors in health

care costs. The cost of drugs—both  
prescription and nonprescription—is  
another.

And when it comes to drug  
costs, the nation's pharmacists are  
concerned. Through their national  
professional society, the American  
Pharmaceutical Association, pharma-  
cists are advising the public to use  
nonprescription medication cau-  
tiously and conservatively, and to seek  
the advice of their pharmacist before  
selecting or purchasing such drugs.

#### Outdated Laws

The pharmacist also is aware  
that when it comes to prescription  
drugs, often he has an even greater  
opportunity to reduce the cost to the  
patient—with no sacrifice in the qual-  
ity of the medication dispensed. But  
in many states, outdated and anti-  
quated laws prevent the pharmacist  
from engaging in drug product selec-  
tion. "Drug product selection" simply  
means that the pharmacist functions  
in the patient's interest by con-  
sciously choosing, from the multiple  
brands available, a low-cost quality  
brand of the specific drug to be dis-  
pensed in response to the physician's  
prescription order.

Much *misinformation* has been  
purposely spread by those who stand  
to gain financially by maintaining

high drug costs to the public. An end-  
less stream of propaganda has ema-  
nated from the drug industry in an  
effort to persuade the medical profes-  
sion that these so-called anti-substitu-  
tion laws should be retained. And as  
long as these laws are retained, the  
drug industry will continue its current  
marketing practices which contribute  
unnecessarily to high drug costs to  
patients. These practices also are in-  
viting government agencies to expand  
their restrictive controls on physi-  
cians and pharmacists.

#### APhA Efforts

As pharmacists, we are con-  
cerned about health care costs. We  
hope that every physician shares our  
concern on this vital issue, and will  
give his personal support to the con-  
structive efforts APhA has undertaken  
in the interest of all patients.

(For a complete discussion of  
drug product selection, you are invited  
to request a free copy of the "White  
Paper on the Pharmacist's Role in  
Product Selection" from: American  
Pharmaceutical Association,  
2215 Constitution Avenue, N.W.,  
Washington, D.C. 20037.)

30 drugs that he selects to treat the  
majority of conditions encountered in  
his practice. Moreover, the physi-  
cian's choice of a specific brand is  
based on his knowledge of the pa-  
tient's medical history and current  
condition, and his experiences with  
the particular manufacturer's  
product.

Some substitution proponents  
have argued that the dispensing of a  
prescription is a simple two-party  
transaction between the pharmacist  
and the patient, and that a substitut-  
ing pharmacist may avoid even a  
technical breach of contract by simply  
notifying the patient that he is making  
the substitution. I would judge that  
few courts would be sympathetic  
toward a pharmacist who substituted  
without physician approval and who  
undertook a legal defense that seeks  
to make the patient responsible for  
the pharmacist's actions.

#### Reduced Prescription Prices?

Substitution advocates are  
suggesting to the consumer, and par-  
ticularly the consumer activist, that  
reduced prescription prices could  
follow legalization of substitution.  
We have seen absolutely no evidence  
to justify this claim. To the contrary,  
experience in Alberta, Canada, where  
substitution is authorized, suggests

the opposite.

Many pharmacists understand-  
ably are concerned about the cost of  
maintaining multiple stocks of similar  
products. While there is no doubt that  
inventory costs rise when additional  
brands are stocked, it would be inter-  
esting to know how much they rise,  
and how many pharmacists actually  
stock *all* brands—of, say, ampicillin  
or tetracycline—or how long they  
keep "slow moving" products on their  
shelves before they are returned for  
credit. To ask that the industry elimi-  
nate multiple sources is to ask com-  
petitors to stop competing.

#### Drug Substitution—A License for the Unethical

Anti-substitution repeal would  
favor "corner cutting" pharmacists  
and manufacturers. For them, free  
substitution would be not a right, but  
a license. As an aftermath, it is quite  
likely that the confidence of both phy-  
sicians and patients in the profession  
of Pharmacy would be eroded, as  
revelations about the unconscionable  
behavior of an undisciplined few were  
magnified in the press or in profes-  
sional circles.

#### Summary

In short, what the American  
Pharmaceutical Association advo-

cates as a broad-spectrum panacea  
looks to us to be not only a minority  
view (advocacy of substitution is by  
no means a uniform policy in Phar-  
macy), but also an extraordinarily  
costly and ineffective remedy, whose  
side effects are odious. We believe  
(1) that an impressive majority of  
pharmacists prefer to work with  
Medicine and with industry, for the  
consumer, and for the general good,  
(2) that they seek the privilege to sub-  
stitute when the patient might gain  
and when the patient's doctor agrees,  
and (3) that they seek to work for the  
resolution of genuine grievances  
openly and professionally.

(For amplification of PMA views,  
please write for our booklet, "The  
Medications Physicians Prescribe:  
Who Shall Determine the Source?"  
It is available from: Pharmaceutical  
Manufacturers Association, 1155  
Fifteenth Street, N.W., Washington,  
D.C. 20005.)

Pharmaceutical  
Manufacturers Association  
1155 Fifteenth Street, N.W.  
Washington, D.C. 20005



## University Med School Graduates 91 M.D.s

A record-breaking class of 91 earned the doctor of medicine degree at The University of Mississippi Medical Center 17th annual Commencement on May 27, with Steve Hindman of Newton taking top honors as winner of the coveted Waller S. Leathers Award.

During the afternoon ceremony at the city auditorium in Jackson, Chancellor Porter L. Fortune, Jr., conferred an all-time high of 174 degrees. In addition to the medical graduates, there were 41 for the bachelor of science degree in nursing, 18 for the master of nursing, 16 for the Ph.D. and eight for the master's in an advanced health science.

Both medical and baccalaureate nursing classes were the largest in the histories of their respective schools.

Gen. Harold K. Johnson, president of Freedoms Foundation at Valley Forge, made the Commencement address.

The graduation exercises concluded a full day's activities for graduates and their families, including a breakfast hosted by The University of Mississippi medical alumni and the Chancellor's reception that afternoon.

## Dr. Wesley Hall Speaks at UMC



*Dr. Wesley Hall, second left, a past president of the American Medical Association, was Student Assembly speaker at the University Medical Center in May. Talking with him after his talk are, from left, University of Mississippi School of Medicine seniors Rodney Meeks of Jackson, Patricia Ainsworth of Taylorsville and Troy Watkins of Natchez. Dr. Hall is a native Mississippian.*

## Golden Triangle Will Initiate MH-MR Services

Dr. Jo N. Robinson, president of the Region 7 MH/MR Commission, has announced that the region's first mental health services will be available in July. The regional center will offer mental health, mental retardation, and alcoholism services in the form of outpatient diagnosis and treatment, consultation and education. Dr. John R. Hutcherson will direct the program.

A comprehensive mental health center staffing grant was submitted to federal authorities by the Region 7 Commission in January but has not been reviewed because of the Nixon Administration cutbacks. The commission budget has been revamped for a more limited program operation. Funds will come from a 1/2 mill tax levy in each of the seven counties served—Webster, Clay, Choctaw, Oktibbeha, Lowndes, Winston and Noxubee. Dr. Robinson said the commission also hopes to receive some of the counties' revenue sharing funds. A developmental disabilities grant from the Mississippi Interagency Commission will supplement the county tax funds. Alcoholism program funds are being sought from the State Board of Health.

Each county will have an advisory committee to provide community consultation for policies made and implemented by the new center's staff.

## Malnutrition Is Major Health Problem

Special attention is called once again to the National Nutrition Survey of people of low income showing that a large section of the population is malnourished in a recent editorial in the *Journal of the American Medical Association*.

Written by Philip L. White, Sc.D., director of the AMA's Department of Foods and Nutrition, the editorial reminds that improper nutrition is a major health problem in the United States, especially among the black population.

The survey report was announced last summer in publication of five large volumes, covering four years of work. Although it was widely publicized at the time, "This information is much too important to the health of the nation to permit it to be a one-time news story that is quickly forgotten," Dr. White said.

The editorial reads, in part, as follows:

"The survey was the most energetic nutri-



tion study ever undertaken in this country. Twenty-four thousand families representing 86,000 persons were evaluated for dietary, clinical, biochemical, anthropometric and dental manifestations of nutritional ill health.

"The report concludes that a significant proportion of persons surveyed were malnourished or at risk of developing nutritional problems. Evidence of malnutrition or the risk of it was commonly found among the black population, less commonly among Spanish Americans, and least among white persons. Prevalence was generally inversely related to income.

"In terms of relative importance, iron malnutrition was of high significance among the blacks of the states with a low income ratio and of medium significance in all other groups except the white population of high income states. Vitamin A status was lowest among the Spanish American people except for the Puerto Ricans of New York City.

"Riboflavin intake was low among segments of states with a low income ratio. Adolescent boys had more evidence of malnutrition than girls. Adolescents in general had the highest prevalence of an unsatisfactory nutritional status. Obesity was confirmed as a major problem, with more than 50 per cent of the adult black women in some age groups being obese.

"Problems were found most often with the following nutrients: iron, vitamin A, riboflavin, and protein (among pregnant and lactating women). Undesirably low intakes of ascorbic acid were found among males of the states with low income ratios."

Dr. White said that full copies of the report may be obtained from the U. S. Department of Health, Education and Welfare, Health Services and Mental Health Administration, Center for Disease Control, Atlanta, Ga. 30333.

## AMA Testifies on Medical Research Subjects

The use of human subjects in medical research is essential for the benefit of society despite the fact that it will place some participants at a calculated disadvantage, the American Medical Association told Congress.

The AMA comments were made to Senator Kennedy's Senate health subcommittee in hearings on the subject of human experimentation and if a need exists for federal legislation to forestall abuses.

Dr. William R. Barclay, Assistant Vice-President of the AMA, told the senators that, "The practice of medicine is both an art and a science, and we are constantly seeking new means to improve the quality and length of life. The evolution of sound medical practice through the years has reduced the incidence of pain and has done much to advance the cause of human dignity. These procedures, however, today as always, require the weighing of risk against benefit at every level of professional discretion. It is evident that there is a certain degree of risk attendant to any medical procedure.

"But if we are to continue to improve our high standards of patient care, we must maintain our initiatives in biomedical research. The accomplishments of modern medical practice testify to the merits of continued research. Such advances are hard won, but the benefits are beyond question.

"Medicine as a science must conduct experimentation if it is to progress rather than stagnate. Experimentation is an essential principle of all sciences, be they biological or physical. Scientific experiments are conducted both to test new hypotheses and to reexamine the validity of accepted hypotheses.

"A medical experiment with human subjects is sometimes referred to as a clinical trial. As such it should be a test of a reasonable hypothesis based on sound laboratory data. It should not be a random groping for information. A well designed clinical trial has elements in its design which assure that it will be a useful and a justifiable undertaking.

". . . A human experiment, by its very nature, establishes a set of circumstances which will place some of the participants at a calculated disadvantage. Generally a trial is established to answer the question, 'Is treatment A better than treatment B?' No definitive answer to this question can be obtained until the test is conducted over an adequate period of time and sufficient data has been gathered by which to measure the relative response of the subject.

". . . Through the process of clinical investigation, which we have described here, drugs and procedures become available for widespread usage in patient care.

". . . We note that it is the committee's hope that these hearings will encourage continued support of and advancement of biomedical research. If we are to continue to increase our knowledge and continue to improve medical care for the benefit of society, medical research using human subjects is essential," Dr. Barclay concluded.

## Uniform Test Urged For Sick Cell

Some of the blood tests used in mass screening programs for sickle cell anemia emergency among American blacks have not been sufficient to find all of the abnormal blood traits (hemoglobin anomalies) that can cause serious health problems and that can be genetically transmitted, says a report in the May 28 *Journal of the American Medical Association*.

The report is from the Center for Disease Control of the U. S. Public Health Service at Atlanta.

The study calls for national uniform methods of screening to insure that genetic counselors have full information in informing potential black parents of the risk involved.

"There is little question that sickle cell screening should be done," says Dr. Robert M. Schmidt, author of the report. He cites incidence figures to show that sickle cell disease is a serious health problem.

"Without a uniform standard of screening, however, the program will not succeed. With well over 100 screening programs now in existence, we are already too late to prevent past errors in diagnosis. There is still time, however, for screening programs to change to methods that will allow identification of the clinically important abnormal hemoglobins."

The CDC is currently offering training courses in laboratory methods of blood testing for anyone involved in the screening process. These courses, which are free, stress an initial screening test known as cellulose acetate electrophoresis. The test is inexpensive, easy to perform, allows differentiation of sickle cell disease from the relatively benign carrier state, and detects other common abnormalities so that effective counseling is possible, Dr. Schmidt says.

Sickle cell anemia affects at least one in each 500 black infants. A census study in 1967 showed 1,155 new cases of the disease in that year. The sickle cell trait is present in 8 to 14 per cent of American blacks. Fortunately, the trait actually causes the disease in the offspring of only a relatively small portion of the carriers.

There are several basic sickle cell screening tests that are done in the laboratory with blood samples, Dr. Schmidt says. The one most widely used in the past is known as the sodium metabisulfite test. It requires interpretation by an experienced technologist, is time-consuming and is not

well adapted to large-scale screening, he reports. The best of the tests, he says, is that mentioned earlier—cellulose acetate electrophoresis.

"The National Sickle Cell Disease Program, the Howard University Sickle Cell Conference, and the New York City Sickle Cell Conference all recommend electrophoresis as the primary screening test for any hemoglobinopathy (blood disorder) program. Until a better method is developed, a uniform national program will be possible only if all those involved in sickle cell screening come to an agreement on methodology."

## Dr. Riley Named Southern Med Editor

Dr. Harris D. Riley, Jr., professor of pediatrics and head of the Department of Pediatrics, University of Oklahoma College of Medicine and pediatrician-in-chief of Children's Memorial Hospital, University of Oklahoma Health Sciences Center, Oklahoma City, has been named editor of the *Southern Medical Journal*.

Dr. Riley has previously served as pediatric editor, assistant and associate editor of the *Journal*. Published monthly by the Southern Medical Association (SMA), at the headquarters in Birmingham, Ala., the *Journal* is for SMA members and is the selected publication for physicians and students who want to keep up-to-date on the very latest techniques, and who are profoundly interested in the practice of better medicine.

A native of Tupelo, Miss., Dr. Riley received the M.D. degree from Vanderbilt University School of Medicine. He served his internship and residency training at the Johns Hopkins Hospital and Baltimore City Hospitals, Baltimore, Md.; the Babies and Children's Hospital, Western Reserve University, Cleveland, Ohio; and the Vanderbilt University Hospital, Nashville, Tenn. Following military service he returned to Vanderbilt University School of Medicine as a research fellow of the National Foundation.

Dr. Riley is consultant to several organizations, including the National Institute of Child Health; the U. S. Public Health Service; the Communicable Disease Center, and the U. S. Army Medical Corps.

Certified by the American Board of Pediatrics, he holds membership in many medical and scientific organizations, including the Society for Pediatric Research, the American Pediatric Society, the Infectious Disease Society of America and the American Academy of Pediatrics.



# Antisubstitution Statement Adopted

Twelve medical, dental and pharmaceutical organizations have adopted a joint statement in support of the traditional prescription drug antisubstitution laws and regulations.

They include:

- the American Academy of Dermatology
- the Board of Directors of the American Academy of Family Physicians
- the Executive Board of the American Academy of Neurology
- the Committee on Drugs of the American Academy of Pediatrics
- the American College of Allergists
- the Executive Committee of the American College of Obstetricians and Gynecologists
- the Board of Regents of the American College of Physicians
- the Board of Trustees of the American Dental Association
- the Board of Trustees of the American Medical Association
- the American Psychiatric Association
- the Executive Committee of the National Association of Retail Druggists
- the Board of Directors of the Pharmaceutical Manufacturers Association.

Patient welfare is best served by present antisubstitution laws and there are no convincing reasons to modify or repeal them, the groups note in the statement. "Since drug product selection entails knowledge derived from clinical experience," it says, "the role of physicians and dentists in product selection remains primary and does not permit delegation of decisions requiring medical and dental judgment."

The statement is a response to attempts in some states to repeal or modify current laws and regulations so that pharmacists could substitute any firm's product for the one specified by the physician or dentist on a patient's prescription.

The statement declares: "The physician or dentist is clearly the one to exercise control over patient therapy. They have much more information about the patient with which to make a prescribing decision than does a pharmacist.

"Antisubstitution laws have not obstructed enhancement of the professional status of pharmacy . . . as a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and as-

sure each profession the opportunity to exercise fully its expertise in drug usage to the advantage of patients.

"The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients."

## Safety Restraints Urged for Children

Thousands of injuries and deaths of small children in automobiles can be prevented by the use of proper safety restraints inside cars, says an editorial in the February issue of the *American Journal of the Diseases of Children*, an AMA publication.

The AMA and the American Academy of Pediatrics have joined in initiating an educational campaign on safe child restraint systems for automobiles, the editorial says. Author is Lee N. Hames of the AMA's Department of Health Education.

The editorial appeals to physicians whose patients include families with small children to take the lead in informing parents about proper child safety precautions in autos.

"Parents should be told, for instance, that flimsy child seats which hook over the back of the automobile seat are completely inadequate, and that seats with attached toys, steering wheels and other gadgets may actually increase the hazard to the child.

"They should be told, also, to purchase only those restraints which incorporate use of the adult seat belts already in the automobile. They must understand, at the same time, that under no circumstances should children use the adult seat belt as their sole protection until their pelvic structures are sufficiently developed, usually not before four and one half or five years of age."

The two medical organizations express the hope that their educational campaign "will create such a huge public demand that automobile salesrooms, hardware stores, department stores and gasoline stations can no longer refuse to carry child restraint equipment on the grounds that there is little call for such items."

## New Family Practice Journal Is Coming

Family practice—the newest and fastest growing medical specialty—soon will have its own scholarly journal to report new developments in the field. According to a joint announcement by Dr. John P. Geyman, editor, and Appleton-Century-Crofts, publisher, *The Journal of Family Practice* hopes to publish its initial issue late this fall, with regular publications beginning in January, 1974.

Dr. Geyman, professor and vice chairman of the Department of Family Practice at the University of California, Davis, heads an editorial board of seven distinguished teachers of family practice from throughout the United States and Canada.

The editorial board will set direction for the new journal and attempt to insure that it meets the following objectives—as listed in the journal's statement of purpose:

- create a forum to stimulate the development of a firm literature base for all aspects of family practice

- build the framework of family medicine as the academic discipline of family practice

- synthesize clinical, educational and research aspects of family practice in one journal for the family physician

- serve as a catalyst for research in family practice

- provide an unique mechanism for continuing medical education through self-assessment.

Dr. Geyman said the need for the new journal had become clear in the past year because of the remarkable growth in the new specialty and increasing interest among medical students currently in training.

“As a developing specialty requiring definition as an academic discipline,” according to Dr. Geyman, “we must have a journal responsive to our particular needs.” The journal is not to be viewed as being in competition with any existing—or announced—literature in the field.

The philosophy of the new journal is further explained in the statement of purpose:

“Family practice as a field has a strong tradition of service through patient care, but a weak tradition for literature. As this specialty now assumes its rightful place in both undergraduate and graduate medical education, there is a critical

need to better define family practice as a clinical discipline. The specialty has taken birth from general practice, and has broadened its content and concern to meet the needs for more comprehensive care of families. The academic discipline of family medicine must be articulated, together with the relationships of family practice to other clinical disciplines and new methods of delivery of health care.

*The Journal of Family Practice* is conceived as a scholarly publication which will reflect high educational standards as the basis for high practice standards. The journal will attempt to take an honest and nonpolitical approach in developing a new body of literature for family practice.”

According to Dr. Geyman, the new journal will concern itself primarily with maintaining “clinical excellence” and, therefore, will rely heavily on the contribution of articles on clinical subjects directed specifically at family physicians. In conjunction with its clinical articles, the journal will attempt to develop a convenient and effective mechanism of reader self-assessment. This is important, Dr. Geyman pointed out, because family practitioners are currently the only medical specialists who are required to have their competence recertified periodically.

“Our journal,” he explained, “not only will supply clinical information that is sufficiently relevant and comprehensive to aid significantly in a physician's maintaining his competence, but hopefully will give him the capability to test his knowledge during intervals before recertification.”

The journal is to be published by the Medical/Nursing Department of Appleton-Century-Crofts, 440 Park Avenue South in New York City.

In addition to Dr. Geyman, the editorial board of the new journal includes: Dr. Hiram B. Curry, professor and chairman of Family Practice, Medical University of South Carolina at Charleston; Dr. Silas W. Grant, assistant professor of Family Practice at the University of Iowa College of Medicine, Iowa City; Dr. Brian Hennen, assistant director of the Family Medicine Centre at St. Joseph's Hospital, London, Ontario; Dr. Edward M. Neal, assistant clinical professor at University of California, San Francisco, and a family physician in Healdsburg, Cal.; Dr. Theodore J. Phillips, associate professor and chairman of Family Medicine at the University of Washington School of Medicine, Seattle; and Dr. Gayle Stephens, professor and chairman of Family Practice at the Kansas University Medical School, WSU Branch, Wichita.



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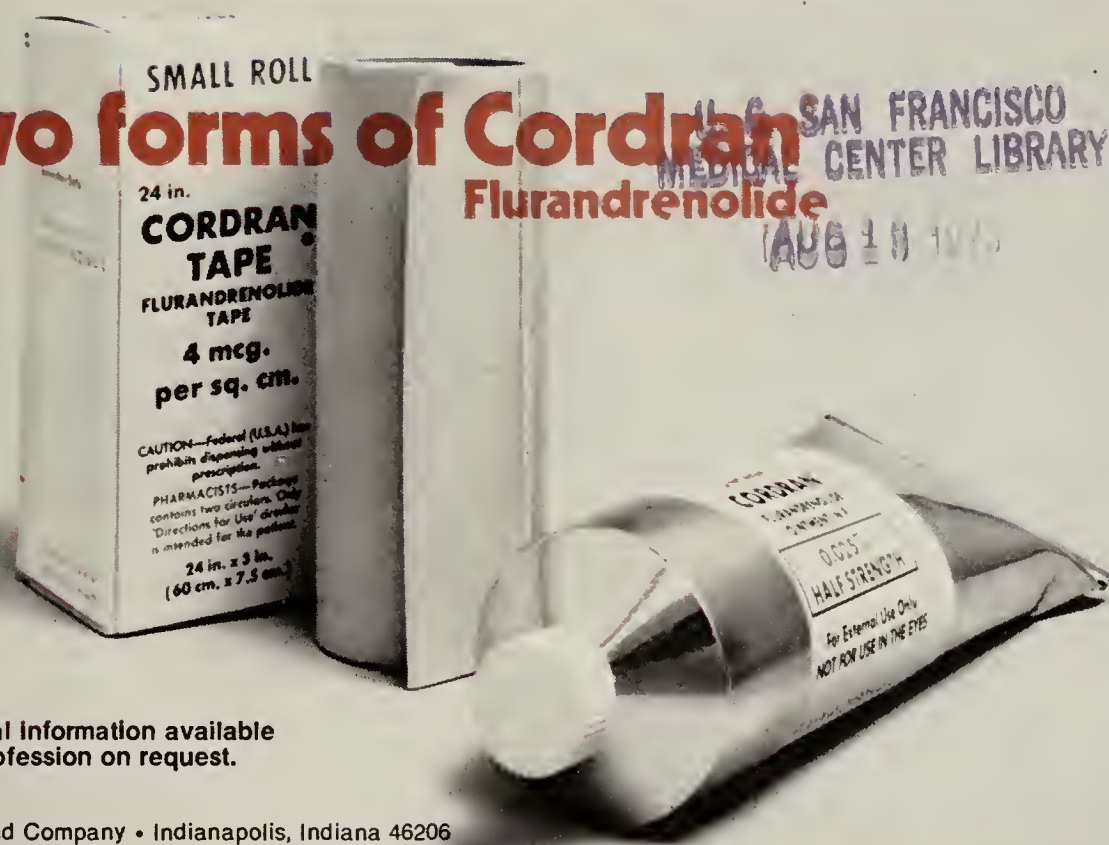
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*This Month . . . Pulmonary*

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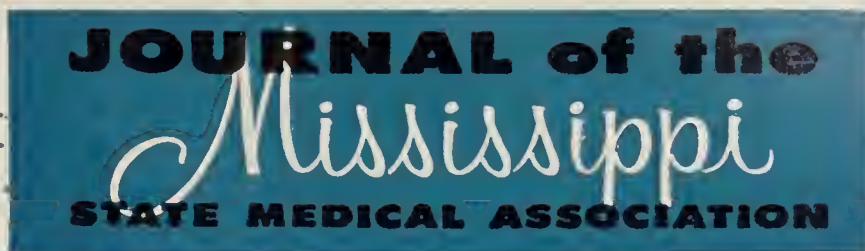
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Volume XIV

Number 8

August 1973



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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$7.50 per annum; \$1 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri.

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# What's on your patient's face...

may be more important than his chief complaint

Patient P.T.\* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.



Patient P.T.\* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

\*Data on file,  
Hoffmann-La Roche  
Inc., Nutley, N.J







ORIGINAL PAPERS

## Case Report XV of Maternal Mortality Study

K. RAMSAY O'NEAL, M.D.

Hattiesburg, Mississippi

THE FOLLOWING case report represents a maternal death in a 42-year-old grand multipara due to bacteremic or endotoxic shock. The infection occurred after prolonged labor, rupture of membranes 48+ hours prior to Cesarean section and subsequent pelvic cellulitis.

CASE NO. 737-11131-71

A 42-year-old gravida XVII, para XV, stillborns II, was admitted to the MBCH Hospital in labor at 10:00 a.m. on Aug. 10, 1971. Her last menstrual period was Oct. 3, 1970. Her prenatal course indicated that the patient had a weight gain from 270 pounds to 292 pounds and her persistent prenatal blood pressure was 160/100, with the patient having a history of essential hypertension for several years and no other significant past history.

The patient was in active labor, having contractions every two minutes with the fetal heart tone being 140 per minute. The cervix was 4 cm. dilated and 35 per cent effaced with the presenting part being quite high. Blood pressure was 160/102.

The membranes apparently ruptured about 11:00 a.m. on Aug. 11, 1971, and at 10:00 a.m. on Aug. 12, 1971, a consultation was requested. The consultant remarked that the patient was markedly obese, weighing approximately 300 pounds with 4+ pitting edema and a blood pres-

sure of 160/120 with a temperature of 101.5. Presumably, he heard a fetal heart tone at that time. Vaginal examination showed that the cervix was 7 cm dilated, approximately 50 per cent ef-

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*This is the case report of a 42-year-old female, gravida XVII, para XV, stillborns II, who died approximately one week after delivery by Cesarean section, having had amnionitis approximately 48 hours prior to Cesarean section and also having severe pelvic infection following surgery. She was diagnosed as having septic or endotoxic shock secondary to amnionitis prior to delivery and pelvic cellulitis following Cesarean section, which was done some 72 hours after the onset of labor. The committee discusses the case, rates it as avoidable and points out professional responsibility in a high risk patient.*

---

faced, and the vertex was still quite high. The estimated weight of the baby was 8 to 9 pounds. The consultant noted that the patient had been in labor for approximately 50 hours and had had ruptured membranes for over 24 hours, with the labor pattern being described as dysfunctional.

"In view of the patient's obesity, hypertension, the prolonged labor, severe preeclampsia and rupture of membranes for over 24 hours, it was

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Obstetrics and Gynecology member, Committee on Maternal and Child Care.

## MATERNAL MORTALITY / O'Neal

felt that it was best to stabilize the patient's condition medically with diuretics and other symptomatic medications, etc., prior to surgery in this high risk patient, as well as to "institute treatment for inertia for several hours." No definite method of treating inertia was reported by the reporting physician.

On Aug. 13, 1971, after there was no apparent progress in the arrested labor, it was felt necessary to deliver the patient by abdominal section which was done under local anesthesia in order to avoid the additional risks of general anesthesia. A stillborn male fetus weighing 8 pounds, 8½ ounces was delivered through a transverse incision in the lower uterine segment. Blood loss was estimated at 200 cc with no replacement being required.

The patient was transferred to the recovery room with the prognosis at this time being considered quite guarded because of the previously mentioned complications. Some 15 hours after surgery it was noted that the patient had oliguria and measures were taken to increase the urinary output. Intravenous administration of Manitol gave a satisfactory response and the patient began to have what was felt to be satisfactory urinary output and in general made a satisfactory initial recovery.

On Aug. 17, 1971, the patient began to vomit a greenish fluid in copious amounts and continuous suction was instituted. It was also noted that on the third postoperative day some of the stitches had been removed because of serous drainage from the incision and a moderate seroma was noted, but the wound was otherwise felt to be satisfactory, considering the patient's marked obesity. The wound was redressed daily and Furacin dressings applied. The patient was progressing moderately satisfactorily. She became afebrile and kidney function was reported to be improving.

On Aug. 20, 1971, the patient's family arrived at the hospital and without previous announcement insisted on moving the patient elsewhere against the advice of the attending physicians. The family had been kept informed of the gravity of the patient's illness and the guarded prognosis, but they insisted upon moving her in spite of the risk involved, which was emphasized to the family. It was also suggested to the family that if such a risk of moving were to be undertaken, it would be in the patient's interest, then, to transfer her to the University of Mississippi Medical Center in Jackson. Previous telephone consultations had

been held directly with the head of the Renal Unit of UMC. However, the family was not agreeable, and moved the patient against advice to the North Sunflower County Hospital at Ruleville. The patient was accepted by this institution in a comatose condition with an overwhelming infection. The reporting physician from that hospital stated that there was purulent material exuding from the entire extent of the abdominal incision. Before adequate evaluation of the patient could be made, the patient expired on Aug. 21, 1971.

This case was reviewed anonymously and in the usual manner by a member of the MSMA Committee on Maternal and Child Care and discussed at a regular, quarterly meeting of the committee. The adequacy of the information received was rated as 3 on the ascending scale of 1 to 5. The committee felt that the death should be classified as an avoidable obstetrical death due to endotoxic or bacterial shock secondary to amnionitis and pelvic cellulitis after Cesarean section which was done some 72 hours after the onset of labor and some 48 hours after rupture of membranes. The adequacy of treatment could not be satisfactorily evaluated because no detailed methods, procedures or medications were given in the report which was forwarded to the committee. However, it should be pointed out that if these very difficult cases are to be handled successfully, all measures must be done in heroic fashion and that certain basic principles must be adhered to if satisfactory results are to be obtained.

## DISCUSSION

We would like to point out certain principles of management that the committee feels are quite necessary in handling such a difficult case.

(1) The treatment of such a difficult, high risk patient, as is identified in this report, should be handled in a qualified medical center, if at all possible.

(2) The danger of rupture of the membranes is an increased fetal and maternal hazard because of possible infection. If the patient is examined at the time of rupture of membranes the danger of endometritis or amnionitis in the mother and pneumonitis in the infant increases in direct proportion to prolongation of the latent period before the onset of labor.

Once the patient has had a vaginal examination the fetus should be delivered in 24 hours or less. If delay is anticipated or delay in delivery is desired, she should not be examined. Antibiotics are not given during the latent period but once the patient develops a fever or is in active labor antibiotics are pushed to the full dosage. Always



keep in mind the pregnant patient's susceptibility to infection especially when the membranes are ruptured, or when there is prolonged labor. Infection with the colon aerogenes group is most likely and may lead to the release of endotoxins and subsequently diffuse intervascular clotting. More rare invaders are *Staphylococcus aureus* and anaerobic *Streptococcus* or *C. welchii* and *C. perfringens*. If infection should occur intrapartum, prompt delivery is most important. Uterine, urinary and blood cultures should be obtained and treatment would be as follows:

- A. CBC and hematocrit.
- B. Type and crossmatch for 2,000 cc of blood.
- C. Urinalysis, plus Foley catheter.
- D. Electrolyte studies daily, sodium, potassium chlorides, carbon dioxide, BUN, creatinine and icteric index.
- E. Measure intake and output.
- F. Temperature, pulse and respiration every 2 hours.
- G. Antibiotic therapy, Penicillin 40 to 60 million units plus Streptomycin 2 to 4 grams, or Ampicillin 2 to 4 grams, or Chloromycetin 4 grams daily.
- H. Transfusions as indicated.
- I. Fibrinogen as indicated.
- J. Aramine or Levophed as indicated.
- K. Hydrocortisone 300 mgms. I.V., stat., and then 100 to 200 mgms. I.V. every 6 hours.
- L. Replace fluid on the basis of intake and output and electrolyte levels.
- M. Heparin in adequate dosage if felt to be indicated by the clinician.

(3) In considering the management of dystocia labor, or in making an attempt to elicit causes of such a complicated problem, it is felt that the amnionitis was the cause of dystocia in this case. A few basic principles are outlined in the handling of dystocia which are felt to be significant in such a case as was reviewed.

A. Cephalopelvic disproportion should not be present if oxytocin stimulation is to be considered.

B. Many authorities feel that oxytocin is contraindicated in a woman who is para V or more.

C. Do not administer oxytocin if there is any doubt about its indication. Omission is better than commission.

D. Sparteine has been used for dystocia but is much less precise than oxytocin and consequently more difficult to control. The response varies greatly from one individual to another. If Sparteine fails and oxytocin is used, there should be an interval of at least two hours between the last dose of Sparteine and the first dose of oxytocin.

E. Dramamine has been advocated by some authorities to increase the contractile efficiency of the uterine muscle and to overcome dystocia. The recommended dosage is 100 mgs. in 10 cc of water given slowly I.V. If given too quickly it causes nausea, vomiting, and a rise in the blood pressure. Some physicians are enthusiastic about these drugs; others are not convinced that labor is shortened substantially.

## SUMMARY

A maternal death due to bacteremic or endotoxic shock secondary to prolonged labor, prolonged rupture of membranes, amnionitis, pelvic cellulitis following Cesarean section in a 42-year-old grand multipara has been reported. The Committee on Maternal and Child Care felt that, under ideal conditions, this death could have been prevented in this high risk patient with heroic measures of treatment. It is emphasized that such high risk cases could be more competently handled in a medical center type atmosphere and that all measures of treatment must be heroic if satisfactory, successful results are to be obtained.

★★★

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## SOMETHING TO REMEMBER

The rung of a ladder was never meant to rest upon, but only to hold a man's foot long enough to enable him to put the other foot somewhat higher.

—Thomas Huxley

# Pulmonary Embolism— An Unsolved Problem

DONALD A. HOPKINS, M.D.  
Jackson, Mississippi

IT HAS BEEN STATED that pulmonary embolism kills 47,000 patients in this country annually. However, this estimate is probably low due to the protean nature of the signs and symptoms of pulmonary embolism. In a large number of cases of pulmonary embolism, this diagnosis is never considered premortem, which fact is illustrated by the large number of patients with "unsuspected" pulmonary embolism found at autopsy.

With these considerations in mind, and with a view to determining associated pathological and clinical findings which would at least lead the clinician to consider pulmonary embolism in certain cases, a two-part retrospective study was undertaken.

## I. PULMONARY EMBOLISM: A PROFILE OF 100 CASES REPORTED AT AUTOPSY

One hundred autopsy records on patients who were found to have pulmonary embolism at gross autopsy were studied in detail. The embolism was not necessarily the cause of death in these patients. In fact, the actual pathological causes of death were quite varied. These autopsies were performed in a university medical center during the past five years.

Pulmonary embolism was found to be equally common in both male and female patients. Also, no significant difference in pulmonary embolism among racial groups was noted. Age distribution revealed the largest number of patients (28 per cent) to be in the seventh decade as opposed to other 10-year age groups. Only four per cent of this series were under 20 years of age.

Almost every hospital service was represented in these autopsy reports. Forty-nine per cent of the cases were from the general medical service and 27 per cent from the general surgical service. All other services, including gynecology (one per cent) and orthopedics (two per cent), had less than six per cent each.

In a majority of cases, pulmonary emboli were multiple (89 per cent); in only 11 per cent was

a single embolus found. In some 30 per cent, pulmonary infarction was noted by gross observation and was later confirmed by microscopic exam-

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*The author gives a profile of 100 cases of pulmonary embolism reported at autopsy at the University Medical Center during the past five years. He notes that the nature of pulmonary embolism is such that it is generally associated with another underlying pathological condition and he describes some of these commonly associated processes. Fifty-six cases in which pulmonary embolism was the primary cause of death were also reviewed.*

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ination. The location of emboli in pulmonary vessels revealed major trunks and arteries to be most frequently involved, as opposed to smaller vessels. There appeared to be a slight predilection for emboli to move into the arteries of the lower lobes as compared to the upper lobes.

In most cases no site of venous thrombosis or venous intimal damage was noted by the pathologist. However, 14 per cent of these patients had thrombi in the right atrium, 4 per cent in the inferior vena cava, and 4 per cent in the iliac veins.

A variety of associated pathological conditions was noted in the autopsy reports (see Table I).

## DISCUSSION

It is interesting to note the small incidence of pulmonary embolism in the patients of the younger age groups (0-20 years). Obviously, in order to develop a pulmonary embolus, a venous thrombosis must first be present. It has long been recognized that three factors predispose to venous thrombosis: (1) hypercoagulable state of the blood; (2) stasis of blood flow; and (3) damage to intima of vein wall. One could speculate that because of the increased motor activity of younger patients, venous stasis is rarely encountered. Also, changes in the vein wall due to aging are minimal.

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From the Department of Surgery, University of Mississippi School of Medicine, Jackson, Miss.



In this group of patients it was gratifying to note that only a small number were from the gynecological or orthopedic services. In many previously reported series, a high incidence of pulmonary embolism had been noted following pelvic surgery and also in elderly patients presenting with hip fractures. The precise reasons for this apparent dissimilarity are unclear at present. Aside from early postoperative ambulation, no routine prophylactic measures are taken, and that practice is common to all surgical services.

It appears that a single pulmonary embolus is unusual. Also, the incidence of infarction in the present series was substantially higher than the 10 per cent commonly reported.

Not surprisingly, in most cases a site of venous thrombosis was not discovered by the pathologist. In the first place, in some cases there was but a single site of thrombosis; and when the thrombus embolized, no gross evidence of its site of origin remained. However, probably more significant is the diligence, or lack of diligence, with which the pathologist searched for a site of venous thrombosis outside the abdominal or thoracic cavity.

Of the several associated pathological conditions noted, many were diseases commonly associated with the aging process. Arteriosclerosis with its complication of myocardial disease was prominent. Pneumonia and obesity were also

prevalent in this series. A number of patients had malignant tumors—and of these, cancer of the pancreas and gastrointestinal neoplasms were most common. This, of course, supports the theory that certain malignancies in some way predispose a patient to development of phlebothrombosis.

CONCLUSION

The nature of pulmonary embolism is such that it is generally associated with another underlying pathological condition. Some of these commonly associated processes have been described.

II. PULMONARY EMBOLISM AS  
PRIMARY CAUSE OF DEATH:  
REVIEW OF 56 CASES

An examination of the autopsy records of the 100 patients studied in Part I revealed 56 to have "pulmonary embolism" listed as the final pathological cause of death. A detailed review of the clinical records of these 56 patients was undertaken. From information available to the physician at the time of the patient's hospitalization, an effort was made to determine any symptom complexes, clinical signs, laboratory or special study results which might alert the physician to the early diagnosis of pulmonary embolism. An additional objective was to establish a profile of the type patient who is most likely to develop pulmonary embolism in a general hospital.

Actually, the correct diagnosis was suspected to some degree in only 55 per cent of this group of patients who suffered from fatal pulmonary embolism. Of those in whom the diagnosis was suspected, only half were then placed on an anticoagulation regime. The reasons for withholding anticoagulatives from this group of patients with suspected pulmonary embolism is not clear in most cases, but there were instances of contraindications to anticoagulation. Also, in some of the

TABLE I  
PATHOLOGICAL FINDINGS ASSOCIATED WITH  
PULMONARY EMBOLISM IN 100 PATIENTS

	<i>Per Cent</i>
Generalized arteriosclerotic disease	32
Postoperative status	30
Congestive heart failure	29
Old myocardial infarction	25
Malignant tumors	22
Pancreas	4
Gastrointestinal tract	4
Prostate	3
Lung	3
Bladder	3
Brain	2
Uterus	1
Breast	1
Kidney	1
Pneumonia	20
Obesity	18
Recent myocardial infarction	15
Cerebrovascular accident	15
Chronic obstructive pulmonary disease	12
Sepsis	8
Post-trauma status	8

TABLE II  
SYMPTOMS NOTED IN 56 PATIENTS PROVEN  
AT AUTOPSY TO HAVE FATAL  
PULMONARY EMBOLISM

	<i>Per Cent</i>
Shortness of breath	60
Chest discomfort	41
Confusion or decreased level of consciousness	34
Apprehension	29
Weakness	18
Hemoptysis	16

PULMONARY EMBOLISM / Hopkins

cases, the embolus was a sudden, catastrophic, fatal event. Of the patients who were receiving anticoagulation therapy, some had received heparin for as long as 50 days prior to death.

What subjective complaints might have alerted the physician to the possibility of pulmonary embolism? The most common symptoms noted and recorded in the clinical records are outlined in Table II. These findings were noted after the diagnosis of embolism became suspect, or in unsuspected cases, within 24 hours prior to the patient's death.

Objective findings in this group of patients were likewise tabulated. These were noted as recorded in the clinical record, either at the time embolism was suspected by the clinician, or if embolism was not suspected, within 24 hours of the patient's death. These findings were organized according to major body systems and are shown in Table III.

As expected, multiple associated clinical problems and diagnoses were recognized in this group of patients prior to death from pulmonary embolism. The most common clinical diagnoses noted are tabulated in Table IV.

Forty-two patients in this group had electrocardiograms, either after the diagnosis of embolism was suspected, or within 24 hours prior to death if embolism was never suspected. The ma-

TABLE III  
OBJECTIVE FINDINGS NOTED IN 56 PATIENTS  
PROVEN AT AUTOPSY TO HAVE  
FATAL PULMONARY EMBOLISM

<i>Cardiovascular System</i>	
	<i>Per Cent</i>
Tachycardia	41
Hypotension	39
Irregular pulse	22
Heart murmur	21
Gallop rhythm	11
<i>Respiratory System</i>	
Rales or ronchi (excluding wheezes)	55
Tachypnea	34
Wheezes	22
Decreased or absent breath sounds	13
<i>Extremities</i>	
Edema	27
Cyanosis	16
Tenderness	13
<i>Other</i>	
Temperature elevation	48
Diaphoresis	22

TABLE IV

MOST COMMON ASSOCIATED CLINICAL  
DIAGNOSES NOTED IN 56 PATIENTS WHO  
DIED FROM PULMONARY EMBOLISM

	<i>Per Cent</i>
*Postoperative status	46
Obesity	32
Congestive heart failure	28
Hypertension	25
Chronic renal failure	23
Arteriosclerosis, generalized	20
Pneumonia	20
Cerebrovascular accident	14
Diabetes mellitus	14
Sepsis	9

\* Note: 56 per cent of these patients in a postoperative state died between the sixth and thirteenth day after surgery.

jority (55 per cent) of these patients exhibited only nonspecific ST-T wave changes. Atrial arrhythmias were noted in 28 per cent and old myocardial infarction in 25 per cent.

Chest x-rays were obtained in 44 of these 56 patients. Common findings noted in the radiology reports are shown in Table V. Only six patients in this group had pulmonary scans but four of these revealed "cold" areas. Likewise, only six patients had pulmonary arteriograms; of these, evidence of embolism was present in every case.

Serum enzyme levels (LDH, SGOT) were abnormal in the majority of the patients in whom they were measured. Lactic acid dehydrogenase was recorded in 26 patients and was elevated in 25. Autopsy revealed infarction in only 15 of that group. Twenty-one of 29 patients in whom SGOT was analyzed had elevated levels; and of these 21, only 10 had infarction at autopsy. Serum bilirubin was elevated in 42 per cent of the patients who were tested. Two-thirds of those with elevated bilirubin levels demonstrated infarctions at autopsy.

When performed, arterial blood gas studies revealed a pattern of hypocarbia, hypoxia, and an elevated or normal pH.

DISCUSSION

The overriding impression from this series is similar to that gleaned from other like surveys: that fatal pulmonary embolism is often totally unsuspected prior to death. Occasionally, even when this entity was suspected, no measures were undertaken to treat it. This is understandable if the patient had some contraindication to heparin therapy (allergy, CVA, peptic ulcer, etc.) or if



the episode of embolism is sudden and initially fatal. However, it appeared from the present series that unless definite signs of embolism were present, the clinician was loath to place the patient on anticoagulation. This study should illustrate that the clinical picture of pulmonary embolism is extremely variable. Furthermore, anticoagulation is by no means the entire answer to the problem of treatment of embolism; witness the fact that several of these patients suffered other emboli while on anticoagulation therapy. Several receiving such therapy did, in fact, die.

TABLE V  
FINDINGS ON CHEST X-RAYS OF 44 PATIENTS  
WHO DIED OF PULMONARY EMBOLISM

	<i>Per Cent</i>
Infiltrate .....	64
Cardiomegaly .....	39
Vascular congestion .....	23
Pleural effusion .....	16
Normal ..	11

The subjective complaints of these patients basically followed, for the most part, a familiar pattern. Shortness of breath and chest discomfort were common; hemoptysis was relatively uncommon. Three other prominent symptoms were noted—confusion, apprehension, and weakness.

The physical findings noted in this group can be consolidated into those related to the cardiovascular system, respiratory system, extremities, and other general findings. It should be noted that no single physical finding was common to all cases; râles or ronchi was the most prevalent, appearing in 55 per cent. Friction rubs were very rare indeed.

Several clinical problems were common in this study group, and “postoperative state” was listed most often. The fact that most patients who died from pulmonary emboli during the postoperative period expired during the second postoperative week was noted. This suggests that perhaps the thrombus which forms initially is detached as the patient becomes more mobile. Again, this emphasizes the urgency in seeking out the initial thrombus so that effective therapy can be initiated before embolization occurs.

Electrocardiographic changes were markedly nonspecific. Right bundle branch block or right axis deviation was conspicuous by its absence in most cases.

Chest x-ray findings were also nonspecific, but an infiltrate was noted in most patients. Pleural

effusion was a comparative rarity; however, normal chest films were even more uncommon.

More specialized tests, such as lung scan and pulmonary arteriograms, were of great help when performed, but in this group of patients they were seldom done. Neither of these tests is diagnostic in itself, but pulmonary arteriogram is probably the most specific test presently available. Pulmonary angiography certainly entails some risk and patient discomfort, but it should be utilized more often where facilities are available. This test should be mandatory if surgical intervention (i.e., vena caval interruption or pulmonary embolectomy) is contemplated. There is a reportedly high false positive diagnosis of pulmonary embolism; therefore, diagnosis must be essentially definite before the patient is subjected to therapeutic or prophylactic surgery.

In this series, abnormal elevations of serum enzymes were very common, whether or not infarction was noted later at autopsy. The LDH appeared to be most specific of the available measurements. Elevated bilirubin levels were also quite common; these values correlated somewhat better with infarction as noted at autopsy.

Arterial blood gases were generally abnormal in a rather consistent pattern. The hypocarbia correlates well with the overt hyperventilation noted in many of these patients and probably explains the normal or elevated pH noted in most cases.

CONCLUSIONS

The clinician must be ever aware of the possibility of pulmonary embolism. It continues to be a problem among patients in the postoperative state, obese patients, and patients with underlying cardiovascular disease. There still seems to be a reluctance on the part of the physician to begin heparinization as soon as the diagnosis of embolism is seriously considered. Perhaps we should paraphrase the old surgical adage, “When you consider a tracheostomy, do it,” and say, “When you consider pulmonary embolism, anticoagulate” while diagnostic studies are in progress. Heparin therapy is not without complications, but pulmonary embolism is already a serious complication!

Complaints of shortness of breath, confusion, and apprehension must not be passed off as “anxiety” in hospitalized patients until such patients have been thoroughly evaluated with pulmonary embolism in mind.

Physical signs of pulmonary parenchymal disease coupled with cardiovascular embarrassment must always suggest pulmonary embolus.

## PULMONARY EMBOLISM / Hopkins

Electrocardiograms and chest x-rays are in themselves nonspecific, but will be of value in supporting the diagnosis of embolism. In a like manner, serum enzyme analysis (SGOT, LDH) and bilirubin levels are not without merit in supporting a diagnosis. No statement as to whether or not pulmonary infarction has occurred can be made on the basis of the enzyme values alone, however.

Blood gases will generally be abnormal in these cases.

Pulmonary arteriograms are very specific but not infallible in the diagnostic armamentarium.

In essence, this study answers few questions but serves to reemphasize several problems and deficiencies in our understanding of pulmonary embolism. Venous thrombosis must be prevented; failing that, it must be detected early enough to be treated effectively before embolism occurs.

Perhaps intensified study for evidence of phlebothrombosis in patients who are already victims of the associated conditions described will be rewarding in preventing this major problem. ★★★

2500 North State Street (39216)

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The Queen of Greece came to Radcliffe to receive an honorary degree. One of the guests at the ceremony was a crusty old psychiatrist. "Come over and meet the Queen of Greece," smiled the dean of Radcliffe. The old psychiatrist shook hands graciously, then cackled to the dean—loud enough for Her Majesty to overhear, "She seems harmless enough. How long has she thought she's the Queen?"

—Miss. Educational Advance



# Proceedings of the House of Delegates

105th Annual Session  
April 30-May 3, 1973  
Biloxi, Mississippi

THE 70TH ANNUAL SESSION of the House of Delegates was convened during the 105th Annual Session of the Mississippi State Medical Association, in pursuance to lawful notice given, on April 30, 1973, in the Top of the Sheraton, The Sheraton-Biloxi, Biloxi, Mississippi, at 9:00 o'clock in the morning by Dr. Charles R. Jenkins of Laurel, president. The invocation was spoken by the Rev. Father Kenny of Our Lady of Sorrows Catholic Church of Biloxi.

After extending greetings, Dr. Jenkins presented the vice speaker, Dr. Walter H. Simmons of Jackson, and the speaker, Dr. John B. Howell, Jr., of Canton, who assumed the chair. Dr. Raymond S. Martin, Jr., of Jackson, chairman of the Reference Committee on Credentials, reported the presence of a quorum of 90 registered and seated delegates in accordance with Section 3, Chapter V, By-Laws of the association.

## ANNOUNCEMENT OF REFERENCE COMMITTEES

### Reports of Officers and Board of Trustees

Sidney O. Graves, Natchez, Chairman  
Victor Landry, Lucedale  
William H. Preston, Booneville  
Joseph E. Johnston, Mt. Olive  
Jack A. Stokes, Pontotoc

### Miscellaneous Business

Frank W. Bowen, Carthage, Chairman  
William Gillespie, Meridian  
Wendell B. Holmes, McComb  
S. H. McDonnieal, Jackson  
James K. Williams, Pascagoula

### Constitution and By-Laws

Raymond S. Martin, Jr., Jackson, Chairman  
Arthur E. Brown, Columbus  
Tom H. Mitchell, Vicksburg

### Medical Practices

Max L. Pharr, Jackson, Chairman  
Donald R. Ellis, Clarksdale  
George G. Townsend, Forest  
Gilbert R. Mason, Biloxi

Arthur E. Wood, Belzoni

### Rules and Order of Business

Paul H. Moore, Pascagoula, Chairman  
G. Leroy Howell, Starkville  
W. Boyce White, Laurel

### Credentials

Raymond S. Martin, Jr., Jackson, Chairman  
Tom H. Mitchell, Vicksburg  
Ed Pennington, Ackerman

## APPOINTMENT OF TELLERS AND SERGEANTS-AT-ARMS

J. Dan Mitchell, Jackson, chairman (Dr. John C. Longest of Starkville served as Teller on May 3)

W. R. Campbell, Columbia  
Charles M. Moore, Philadelphia

## REPORT OF THE REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

To assist the Speaker and Vice Speaker in the orderly conduct of the proceedings of this House of Delegates, your Reference Committee on Rules and Order of Business makes the following recommendations:

*Conduct of Business:* Under the By-Laws, the business of the House must be conducted according to *Sturgis Standard Code of Parliamentary Procedure*, and the Speaker and Vice Speaker should prescribe the order of business as set out in the By-Laws. To insure proper recording of the transactions, all delegates recognized should identify themselves. Except for distinguished visitors and those having official capacity in the association, unanimous consent should be obtained for extending the privilege of the floor to nonmembers of the House of Delegates. The report of the Reference Committee on Credentials should constitute the formal and official roll call of the House.

*Reference Committees.* The purpose of reference committees is for affording all members of the association an opportunity to discuss their

## HOUSE OF DELEGATES / Continued

views on matters under consideration by the House of Delegates.

*Reports.* All reports and resolutions presented should be referred to the appropriate reference committee by the chair immediately after their presentation, the only exception being those which are of such a nature as to require no further consideration and are, therefore, ready for decision by vote of this House. Reports published in the *Handbook of the House of Delegates* are considered to have been formally presented and should be referred to appropriate reference committees by the chair. Debate should be reserved on all such presentations until such time as the reference committees conduct formal hearings and when they report to the House.

*Resolutions.* To avoid burdensome tasks upon the reference committees and to insure that all members have adequate opportunity to discuss their views, the House should permit no introduction of resolutions after the present meeting except for (1) matters of an emergency nature, the validity of such emergency to be determined by majority vote, (2) matters relating to a scientific section of scientific work, and (3) proposed amendments to the Constitution and/or By-Laws which would then lie on the table for one year.

The report of the reference committee was adopted.

### ADOPTION OF TRANSACTIONS

On motion by Dr. Stanley A. Hill of Corinth, second by Dr. C. D. Taylor, Jr., of Pass Christian, the Transactions of the 69th Annual Session of the House of Delegates, 104th Annual Session of the association, May 8-11, 1972, published in Volume XIII, Number 8, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, August 1972, were adopted.

### REMARKS OF THE SPEAKER

*Dr. John B. Howell, Jr.:* Your Speaker and Vice Speaker extend warm greetings to the 105th Annual Session of our Mississippi State Medical Association and the 70th Annual Session of the House of Delegates.

We hope and believe that every effort possible has been made for your convenience and comfort at this year's annual meeting.

All advance information indicates that this will be one of the most well attended and active meetings in the recent history of the association—and this is good. We have a full scientific agenda—more scientific exhibits by members of the asso-

ciation than at any meeting—and as you can see from your delegates' folders, we have many important matters to decide as members of this House of Delegates.

Your Speaker and Vice Speaker would like to reemphasize that portion of the report of the Chairman of the Reference Committee on Rules and Order of Business where he stated that "the purpose of reference committees (of this House) is for affording all members of the association an opportunity to discuss their views on matters under consideration by the House of Delegates."

Your Speakers respectfully urge your attendance at meetings of reference committees. Discussion is invited when these committees present their reports on Thursday but for orderly conclusions it should be discussion by those who have participated in the formulation of the committee's recommendations.

Your Speakers encourage you to make your decisions in an atmosphere of constructive debate. Parliamentary procedure can be as simple or as complicated as the deliberative body wishes but the quality of its decisions is more likely than not to bear a direct relationship to the uncomplicated, orderly, and courteous manner in which the decisions are reached.

In conclusion, your Speakers promise you our best efforts in conducting the business before this House. We know that you desire to join us in these efforts. Let us be about our business in an informed, constructive and democratic atmosphere.

### REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee appreciates the report and work of our Speaker, Dr. John B. Howell, and Vice Speaker, Dr. Walter Simmons. We know that this House of Delegates wishes to join us in this commendation.

The report of the reference committee was adopted.

### PRESENTATION OF DISTINGUISHED GUESTS

The Speaker presented the following distinguished guests:

Dr. Alton B. Cobb, Director, Mississippi Medicaid Commission.

Dr. Hugh B. Cottrell, State Health Officer.

Dr. Robert E. Blount, Dean and Director, University of Mississippi Medical Center.

Mr. Charles W. Flynn, Director, Mississippi Hospital Association.



Mr. Bill Long and Mr. Jim Alexander, medical student delegates.

Mr. George Butler, president, Mississippi Hospital and Medical Service.

Mr. Sam Cameron, Deputy Director, Mississippi Hospital Association.

Mr. Bud Wright, Director, Officers Services, American Medical Association.

#### ANNOUNCEMENT OF NOMINATING COMMITTEE

Following a recess for caucuses by association districts, the Nominating Committee was announced:

J. V. Ferguson, Jr., Greenwood, District 1.

John R. Lovelace, Batesville, District 2.

Arthur E. Brown, Columbus, District 3.

S. Lamar Bailey, Kosciusko, District 4.

William B. Hopson, Jr., Vicksburg, District 5.

William M. Gillespie, Jr., Meridian, District 6.

Robert S. Cooke, Jr., Hattiesburg, District 7.

Bruce M. Kuehnle, Natchez, District 8.

C. D. Taylor, Jr., Pass Christian, District 9.

Dr. Taylor was elected chairman of the committee which conducted an open meeting on May 2, 1973, and posted the nominations for the information of all members in addition to submitting a written report of nominations to the House of Delegates.

#### ADDRESS OF THE PRESIDENT

The Speaker declared the House of Delegates in open session, and the president, Dr. Charles R. Jenkins, delivered his address. The address has been published separately in Volume XIV, Number 7, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, July 1973.

#### REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee wishes to commend our President, Dr. Charles R. Jenkins, for the outstanding speech he made to the House of Delegates on Monday. Doctor Jenkins has done an excellent job as our president during this year, and we are grateful to him in this regard.

Your reference committee considered Recommendation No. 3 contained in the President's address, namely, that the immediate past-president sit with the Board of Trustees. In considering this recommendation, we particularly note that the immediate past-president has spent a year in medical activities on the state and national level. We believe that we should take advantage of this experience and we, therefore, recommend adoption

of Recommendation No. 3 as contained in the President's address, beginning in 1973.

The report of the reference committee was adopted.

#### REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

Address of the President, Recommendation No. 1. Your reference committee considered Recommendation No. 1 of the President's address which states:

"That the tenure of office of future members of the Board of Trustees be limited to two three-year terms rather than three. The tenure of the present members of the board would not be affected."

Your reference committee recommends that this recommendation be not adopted and be referred to the *ad hoc* study committee noted below.

The report of the reference committee was adopted.

Your reference committee considered Recommendation No. 2 contained in the President's address which states:

"That the President and the Speaker of the House be voting members of the Board of Trustees—this is in line with the AMA, American Academy of Family Physicians, and other national medical organizations."

We recommend adoption of Recommendation No. 2. Your reference committee further recommends that the *Secretary-Treasurer be a voting member* of the Board of Trustees. We recognize that this recommendation represents an amendment to the By-Laws and that amendments to the By-Laws must lay on the table for one day. This latter recommendation could, therefore, not be implemented until the 106th Annual Session.

A substitute motion was put by Dr. C. D. Taylor, seconded by Dr. W. Moncure Dabney, and passed—"That the Reference Committee report be not adopted and be referred to the *ad hoc* study committee noted below." Drs. Jack Stokes, Tom Mitchell, Ellis Moffitt, James K. Williams and Joe Johnston spoke for Recommendation No. 2 in President's address. Drs. Lawrence W. Long, J. T. Davis and Lamar Arrington spoke against Recommendation No. 2. Dr. Charles R. Jenkins discussed Recommendation No. 2.

The report of the reference committee was adopted as amended.

Your reference committee considered Recommendation No. 4 of the President's address dealing with realignment of the nine association districts along with Resolutions No. 2 and 11 below.

## HOUSE OF DELEGATES / Continued

Your reference committee considered the Report of the Board of Trustees pertaining to Resolution No. 5 as contained in the Handbook of the House of Delegates. This resolution recommended that "the Council on Constitution and By-Laws seek appropriate changes in our Constitution and By-Laws" to establish a category of honorary membership within the Association. The resolution was approved at the 1972 Annual Session. Your Council on Constitution and By-Laws recommends the following amendment to the MSMA Constitution and By-Laws to lay on the table for one year as required by that Constitution and By-Laws.

Amend Article IV—MSMA Constitution, Section 1. "Members of the Mississippi State Medical Association. Members shall be active, associate, emeritus, *or honorary*, according to requirements and provisions of the By-Laws. There may also be invited guests. Membership other than associate *and honorary* shall be construed as active in connection with the rights and privileges accruing thereto. (New wording in italics)

Amend Chapter I—MSMA By-Laws, Section 1. "Eligibility. Each component society of the Mississippi State Medical Association shall judge the qualifications of candidates for election to membership therein, which shall be restricted to those persons who hold the degree of Doctor of Medicine from an appropriate accredited source as defined by the American Medical Association, or in lieu thereof, a foreign degree in medicine which is an acceptable equivalent to the Board of Trustees and shall be a citizen of the United States. All candidates for any degree of membership other than associate *or honorary* must be legally licensed to practice medicine in Mississippi. . . ." (New wording in italics)

Amend Chapter I—MSMA By-Laws, Section 3. "Degrees of Membership. Members of the Mississippi State Medical Association shall be divided into the following classifications (a) active . . . (b) associate . . . (c) emeritus . . . (d) *honorary membership. A layman who has rendered meritorious service may on approval and nomination by the Judicial Council be elected to honorary membership by majority vote of the House of Delegates. Honorary members shall not vote or hold office. . . .*" (New wording in italics)

Section 4. Registration Privileges. Only the following shall be permitted to register at any session:

(a) Active members

(b) Emeritus members

(c) Associate members

(d) *Honorary members*

(e) Invited guests

(f) Medical students of American Medical Association approved medical schools who are certified to the Executive Secretary of the Association by their respective deans.

(g) Interns and residents who are graduates of American Medical Association approved medical schools and who are connected with an approved hospital and who are certified to the Executive Secretary of the Association by their respective hospital superintendents in event they are not associate members of the Association.

(h) Commissioned medical officers of the United States Armed Forces who are on active duty and who if not associate members are certified to the Executive Secretary by their Post or Base Surgeons." (New wording in italics)

Mr. Speaker, I move the adoption of this portion of the report.

The report of the reference committee was adopted.

### SPECIAL ADDRESS

Dr. C. A. Hoffman of Huntington, W. Virginia, president of the American Medical Association, addressed the House of Delegates as the principal speaker of the 105th Annual Session.

### REPORT OF THE DELEGATES TO AMA

Your delegates to the American Medical Association, in conformity with custom and past practices, have limited their joint report to this House of Delegates to key policy actions at the annual and clinical conventions. Because of the comprehensive reporting in the *American Medical News* and *Journal AMA* of scientific and subsidiary activities, further reporting of these aspects of the AMA conventions would constitute needless duplication and repetition.

Dr. C. D. Taylor, Jr., of Pass Christian completed the second year of his first full term, Dec. 31, 1972. Dr. G. Swink Hicks of Natchez completed the first year of his second full term Dec. 31, 1972. Dr. Joseph B. Rogers of Oxford (elected in May 1972) entered his first term as AMA Delegate on Jan. 1, 1973. Dr. Stanley A. Hill of Corinth completed the first year of his term as Alternate Delegate. Dr. Arthur E. Brown of Columbus (elected in May 1972) entered his first term as Alternate Delegate on Jan. 1, 1973.

This reporting covers the 121st Annual Convention at San Francisco, June 18-22, 1972, and the 26th Clinical Convention at Cincinnati, Nov.



26-29, 1972. Your delegation is indebted to our president and other officers and members who participated in these conventions and worked with us.

*San Francisco Annual Convention.* The AMA House of Delegates met for a total of 17 hours and 20 minutes and acted on 59 reports and 130 resolutions during the 121st Annual Convention, June 18-22, 1972. Additional time was spent in reference committee discussion. Delegates named Dr. Russell B. Roth of Erie, Pa., President-elect. Other officers were named in the *AMA News*.

Dr. Carl A. Hoffman of Huntington, W. Va. in his inaugural address used as a theme, "A House of Medicine United—or a House Divided?" He spoke out strongly against unionism in our profession. He thought the power of the union was the strike, and a strike, even the threat of a strike, is a threat to withhold services. It is, therefore, a violation of medical ethics. He pointed out that millions of Americans still enjoy a close personal relationship with their physicians.

Dr. Wesley W. Hall of Reno, Nev., retiring president of the AMA, paraphrased President J. F. Kennedy's "Ask not what your profession can do for you, but what you can do for your profession." Dr. Hall said he "attempted to visit with every doctor possible at every medical meeting he attended." He recommended six considerations to the House:

(1) Study of physician manpower supply and medical schools to determine precisely how many doctors the country needs and how they should be distributed.

(2) Better liaison with medical schools.

(3) A national speakers bureau of the AMA.

(4) Improvement of liaison with constituent and component societies.

(5) A management survey of AMA.

(6) A three-times yearly report from AMA to delegates and state society officials showing current AMA membership, state by state.

The House received and adopted results of the first membership opinion poll on critical issues affecting the practice of medicine. Of the respondents, 73.1 per cent recommended that AMA continue to seek to retain the basic principles of private practice in any government enacted health program. Fifty-five per cent preferred the AMA plan of national health insurance over all others. The poll was critical of AMA on some issues and services and also was in accordance with many of the ideas as put forth by AMA.

The House approved a policy opposing employment of physicians' assistants in and by hospitals. The physician must direct the assistant.

Guidelines for compensating physicians for services of physicians' assistants urged legislation to empower State Boards of Medical Examiners to approve a physician's employment of an assistant and to approve proposed functions of the assistant as described by his employer. The use of the term, physician's assistant, refers solely to the new occupations being developed to assist the physician in delivery of personal care services.

The delegates voted to support efforts to increase the number and improve the utilization of medical, nursing and allied health personnel until 1975, and then to re-evaluate needs. They strongly supported and reaffirmed the expanded role for the nurse in providing patient care and related her to physicians' assistants so that complementation and not duplication will be the end result.

Representatives of the AMA, Association of American Medical Colleges, Council of Medical Specialty Societies, American Hospital Association, the public, and the federal government will participate in a liaison committee on graduate medical education and a Coordinating Council on Medical Education. Interns, residents, and even medical students, will shortly be brought into these bodies.

"The AMA does not condone the production, sale or use of marihuana. It does, however, recommend that the personal possession of insignificant amounts be considered at most a misdemeanor with conservative penalties applied." The House also recommends its (marihuana) prohibition for public use.

Doctors' fees can hardly be set by third parties, and only duly constituted members of organized medicine shall determine "usual, customary, and reasonable fees." Most of the discussion was directed at Aetna Life and Casualty Insurance Co.

Other actions included receipt of a report from the Executive Vice-President, Dr. Ernest B. Howard, which delineated the many services rendered by the AMA central office and staff. It was enlightening.

Medical students can be taken into direct membership under a new procedure. The Atlantic City date in 1975 was reaffirmed and in 1976 the convention will go to Dallas.

Fireman's Fund has a new accepted contract for group disability insurance.

Discussion of terms of offices, selection of delegates, numerical representation and geographic representation of the Board of Trustees was held. The Council on Long Range Planning will explore these matters and delegates will vote in November 1972 on Board of Trustees terms.

Dr. Paul Dudley White of Boston received the

## HOUSE OF DELEGATES / Continued

fifth annual Sheen Award (including a check for \$10,000.00) for outstanding contributions to medicine.

(This report was prepared by C. D. Taylor, Jr., M.D., of Pass Christian, Delegate to AMA.)

*Cincinnati Clinical Convention.* The AMA House of Delegates met for a total of 8 hours and 55 minutes and acted on 59 reports and 65 resolutions during the 26th clinical convention, Nov. 26-29, 1972.

The major issue was the recently passed legislation, H.R.1, which authorized professional standards review organizations. The House voted for the AMA to "provide a dominant role of leadership in the implementation of the PSRO program to assure that the best interests of the public and the profession are preserved." An Advisory Committee on Professional Standards Review will be created by the Board of Trustees to help provide input from the medical profession in development of PSRO regulations; to help constituent societies set up PSROs; and to aid in defining appropriate geographic boundaries.

In his presidential address, Dr. Carl A. Hoffman of Huntington, W. Va., emphasized the problems of inadequate catastrophic illness insurance coverage and maldistribution of physicians and reported on his recent trip to England, Sweden, West Germany and the Soviet Union. He was impressed that health care problems, especially maldistribution which limits access to medical care for some citizens, were similar to those in the U. S. despite vastly different economic, political and cultural conditions.

Recent budget restraints recommended by the Board of Trustees were approved by the House, including termination of four councils and six committees. Further economizing resulted in making specialty journals available on subscription only, beginning Jan. 9. The *JAMA* and *Prism*, the AMA's new socioeconomic publication, will be sent as membership benefits.

Delegates voted to limit terms of trustees to two 3-year terms. The matter was referred to the Council on Constitution and By-laws for further study and recommendations.

In adopting a report dealing with new federal regulations in regard to blood collection and distribution, the House recommended that operating standards of the American Association of Blood Banks and the American Red Cross be recognized and accepted; that physicians be represented on any national panel set up to advise on procurement or use of blood, and that programs to increase voluntary blood donation be encouraged.

The Council on Long Range Planning and Development will be expanded to include one intern and resident member of the AMA as a full voting member, and for the first time, a medical student took his seat in the House of Delegates. The House set annual dues for student AMA members at \$15.00.

Delegates were informed that an Internal Revenue Service ruling which barred physicians from withdrawing voluntary contributions to their Keogh Law plan prior to disability or age 59½ will be revised to permit withdrawal of such contributions made to a qualified plan prior to Mar. 6, 1972. The AMA had strongly protested the ruling, and the House complimented AMA staff for its "prompt and effective action."

The House selected Dr. George Hoyt Whipple, winner of the 1934 Nobel Prize in medicine, to receive the Distinguished Service Award of the AMA at the 1973 annual meeting in New York. Dr. Whipple, now 94, won the Nobel Prize for his work in pernicious anemia, particularly in the use of liver in treatment. He was also recognized for founding the University of Rochester School of Medicine and Dentistry.

Leslie Townes (Bob) Hope received the Layman's Citation for Distinguished Service in recognition of his contributions to the Eisenhower Medical Center in Palm Springs, Cal., including its 80-acre site, which total nearly \$1.5 million. Mr. Hope had also staged fund raising dinners which had brought another \$3.5 million to the center.

The House recognized Dr. C. D. Taylor of Pass Christian, retiring delegate from the MSMA, and commended him for loyal and outstanding service.

Dr. William E. Lotterhos of Augusta, Ga., former speaker of the MSMA House of Delegates, was elected chairman of the AMA Council on Scientific Assembly.

(This report was prepared by Dr. G. Swink Hicks of Natchez, Delegate to AMA.)

*Expression of Delegates.* Your AMA Delegates express their appreciation to our own House of Delegates, to the Board of Trustees with whom we sit at all meetings, and to the general officers for support, assistance, and continuing communication so that we may be properly prepared to represent your wishes and policy positions.

### REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered the reports of our Delegates to AMA, Dr. G. Swink Hicks and Dr. C. D. Taylor. We commend them for their work in our behalf. During consideration of their reports, there was strong recommen-



dation that the association go on record as being opposed to the licensing of physician assistants. Such assistants should work under the direct supervision of physicians. We concur with this recommendation.

The report of the reference committee was adopted.

#### REPORT OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

*Organization and Duties.* The Council on Scientific Assembly is a constitutional body of the House of Delegates, charged with the responsibility of planning the annual session of the association to include all scientific activities, programming, and the scheduling of annual session events. The council membership consists of the chairman and secretaries of the seven scientific sections and the secretary-treasurer of the association, a total of 15 members.

*105th Annual Session.* Planning and organization of the 105th Annual Session was initiated in the summer of 1972. The format suggested in the By-Laws and approved by the House of Delegates has been continued with general sessions centered around broad areas of specialty interests. To the maximum possible extent, conflicts in schedules and programming have been eliminated, although as a practical matter, such total elimination is not possible. In some instances, the council has requested and placed essayists from various specialty societies not represented in the Scientific Assembly before section audiences.

We are gratified that at the present annual session, 15 specialty societies have related or concurrent meetings with us. Four medical alumni groups have fraternal and social occasions, and various nonscientific but medically related bodies will meet during April 29-May 3. We continue to believe that providing for and encouraging these related meetings increases the attractiveness of the annual session to the membership and benefits attendance. We are glad to continue support of the Woman's Auxiliary and its concurrent annual session with us.

Medical television on the agenda for the 105th Annual Session will feature films of surgery performed at the V.A. Center in Jackson. Films will be shown on May 1 and 2. We are gratified with the presentations in the scientific exhibit, and we urge every member and guest to view these and the Technical Exhibits.

*Technical Exhibit.* Your council notes that ethical pharmaceutical firms, suppliers, and others eligible for purchase of space in our Technical Exhibit are declining our invitation to participate in growing numbers. This is not confined to Mis-

issippi, because other state medical associations, major state specialty societies, and national organizations are having the same experience.

Federal drug legislation, changing concepts in marketing, and tighter budgets for advertising have taken a toll of technical exhibit revenues. We have circularized more potential exhibitors than ever before, and we continue to do all things possible to increase this participation.

Your council has investigated the possibility of making the annual session self-sustaining. Based upon past registration it would cost some \$10-15 per MSMA registrant to conduct the annual session.

*Headquarters Hotel.* The annual session will be held at the Sheraton-Biloxi for the third year. Based upon action by the Board of Trustees a committee was appointed last fall consisting of the President and Chairman of the Council to review our annual session contract with the Sheraton-Biloxi and to investigate possible new sites for our annual sessions. With respect to the former the Sheraton-Biloxi has implemented certain changes for this year's meeting which hopefully will improve our convention. We urge each registrant to complete the Sheraton "service questionnaire" located in their room so that we may know your views on the services provided by the Sheraton staff at this year's meeting. Pending completion of the Holiday Inn convention hotel in Jackson, the Buena Vista Hotel is the only other facility which can accommodate our annual meeting.

*Expression of the Council.* Your council on Scientific Assembly is grateful for the support, cooperation, and assistance we have received in planning the 105th Annual Session of the association.

#### REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Your committee considered the report of the Council on Scientific Assembly as contained in the Handbook of the House of Delegates. We commend our Council on Scientific Assembly for the outstanding work they have done in organizing the scientific program for this annual session. We especially wish to recognize and thank the council's Chairman, Dr. Raymond S. Martin, Jr., for his work in this regard. We recommend adoption of the Report of the Council on Scientific Assembly.

The report of the reference committee was adopted.

#### REPORT OF THE COUNCIL ON MEDICAL SERVICE

*Organization and Duties.* The Council on Medical Service is a constitutional body of the House

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of Delegates, consisting of nine members, one from each association district, elected for terms of three years each. There are three ex officio members who are our president, president-elect, and secretary-treasurer. The council is charged with the responsibility of ascertaining and studying all aspects of medical care in Mississippi. Under the council's jurisdiction are assigned activities of the association in medical service, emergency service programs, medical care for the indigent, and the work of allied medical agencies and organizations.

The council is assisted by seven committees, five constitutional and two ad hoc. These embrace a wide range of subject areas in our purview of responsibility, including maternal and child care, blood and blood banking, mental health, occupational health, nursing, family planning and college health.

*Maternal and Child Care.* The committee has continued its study of maternal deaths occurring in Mississippi and meets quarterly for this purpose. Individual committee members regularly prepare case reports for publication in the JOURNAL MSMA. During the year the committee was represented on a Committee on Maternal and Child Care panel discussion at the District VII meeting of the American College of Ob-Gyn.

The committee works closely with the Department of Obstetrics and Gynecology at the University Medical Center. The committee plans to update its "Maternal Health Desk Cards" with the assistance of the Department. The committee continues to distribute the cards to hospitals through chiefs-of-staff and chiefs of ob-gyn services.

The committee's chairman is Dr. William B. Wiener of Jackson and the committee has consultants in medicine, pathology, and anesthesiology.

*Blood and Blood Banking.* This committee is responsible for oversight of blood and blood banking activities in Mississippi. The committee chairman is Dr. Warren N. Bell of Jackson.

*Nursing.* This committee was accorded constitutional status at the 104th Annual Session of the association. The committee conducts an active program of liaison with the Mississippi Nurses Association serving as the medical association's representatives on the MSMA/MNA Joint Practice Committee. The chairmen of the two committees attended the National Joint Practice Commission meeting conducted in the Fall of 1972.

During the year the Committee on Nursing has formally responded to the Mississippi Senate

Committee on Public Health in regard to nurse education in Mississippi. Additionally, the MSMA/MNA Joint Practice Committee has given extensive consideration to mechanisms for formalizing the role of the clinical nurse practitioner/physician's assistant with a view toward making recommendations to the House of Delegates in this regard. The chairman of the committee is Dr. Tom H. Mitchell of Vicksburg.

*Mental Health.* This committee is responsible for oversight of mental health activities in the state. The chairman of the committee is Dr. Jerry M. Ross of Whitfield.

*Committee on Occupational Health.* This committee met in July, 1972. Prior to that time the committee had not met formally since March, 1967 when it concluded its study of "Occupational Health Programs in Small Plants." Based upon a review of present programs and activities within the committee's assigned sphere of interest the committee has unanimously recommended that it be absolved as a constitutional committee of the Council on Medical Service and that the association's activities in occupational health be assigned to an *ad hoc* committee as need dictates. The council concurs with this recommendation.

*Committee on College Health (ad hoc).* This committee is charged with the responsibility of stimulating interest in health programs and improvement of health facilities on the college campuses in Mississippi. The committee is in the process of surveying the status of student health programs at the state's universities and colleges and a formal report will be published in this regard.

*Other Council Activities.* The council has continued to monitor the Medicaid Program and is grateful to Dr. Alton B. Cobb, director of the Mississippi Medicaid Commission, for his interest and cooperation in this regard. A member of the council also serves on the Physicians' Advisory Committee to the Mississippi Medicaid Commission.

The council was pleased to review a proposed Regional Medical Program sponsored demonstration project to use allied health professionals to provide medical care under the supervision of physicians in an area with a scarcity of health resources. The council approved the concept of the proposed project and assigned oversight of the project to the Committee on Nursing. Although the future of the RMP is now in doubt with respect to funding of the program after June 30, 1973, the council commends the concept of the project to the House of Delegates.

In other activities the council has appointed a



committee to work with the Committee on Trauma of the American College of Surgeons. The council has also acted to furnish guidance in the formation of an interagency type committee to coordinate cancer projects in Mississippi.

*Council on Medical Education.* Formal development of continuing medical education programs and the certification of such programs as meeting certain "essentials" with respect to format and objectives have been growing in importance during the past decade. During the 1960s the AMA Council on Medical Education developed a program of survey and accreditation for institutions offering courses in continuing medical education on a regional and/or national basis. The "Guide" developed by the council in this endeavor was formally approved by the AMA House of Delegates in 1970, as the "Essentials of Approved Programs in Continuing Medical Education."

During 1971, based upon the interest of local hospitals, medical societies, and voluntary health organizations in development and accreditation of continuing medical education programs, the AMA Council on Medical Education recommended that state medical associations plan and sponsor accreditation programs for continuing medical education activities. "Guidelines for State Medical Association Accreditation of Programs in Continuing Medical Education" were formulated by the AMA Council on Medical Education for this purpose.

Your Council on Medical Education has carefully studied and proceeded with the formalization of a state medical association sponsored program for accreditation of continuing medical education activities in Mississippi for presentation to House of Delegates at the 105th Annual Session. The program will be entirely voluntary as to participants. A subcommittee representing the following specialty groups has worked with the council on this project: Mississippi Chapter, American College of Surgeons; Mississippi Chapter, American Academy of Pediatrics; Mississippi Chapter, American Academy of Family Practice; Mississippi Association of Pathologists; Mississippi Orthopaedic Society; Mississippi Radiological Society; Mississippi Ob-Gyn Society; Mississippi Society of Internal Medicine; and Mississippi EENT Association.

Additionally, recognizing the interest and activity in continuing medical education of the Mississippi Regional Medical Program and the University of Mississippi School of Medicine, the council asked representatives of the two programs to serve on the project.

#### REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

The committee considered the report of the Council on Medical Service as reported on pp. 15-16 of your House of Delegates Handbook. Your committee commends the council for its work and the work of its several committees. The council's Committee on Occupational Health after a review of present programs and activities within the committee's sphere of interest has recommended that the committee be absolved as a constitutional committee. The Council on Medical Service has concurred with this recommendation noting that the association's activities in occupational health can be assigned to an *ad hoc* committee as need dictates. Your reference committee concurs with the recommendation.

The report of the reference committee was adopted.

#### SUPPLEMENTAL REPORT A OF THE COUNCIL ON MEDICAL SERVICE

*Background.* As reported to the House of Delegates at the 104th Annual Session the Council's Committee on Nursing has established a Joint Practice Committee with the Mississippi Nurses Association. The MSMA-MNA Joint Practice Committee has addressed itself to the following general subject areas:

(1) The utilization of nurses in providing health care. Many studies indicate that nurses spend 50 to 75 per cent of their time in non-nursing functions.

(2) The development of a career perspective in nursing practice. Too frequently, the opportunities for advancement in nursing lead away from the patient into nursing administration or education.

(3) The expansion of the role of nurses to ensure that their talents and capabilities are fully used and challenged.

The theme of these several areas of joint physician/nurse concern is role function and in this regard the committee has particularly addressed itself to reinforcing and strengthening the clinical nurse function. This effort touches on many areas of public and professional concern—the distribution of health care services, the relationship of various health care careers, the cost of health services, etc.

In considering an expanded role for the nurse, the Joint Practice Committee has studied programs in other states dealing with this subject area. The Committee recommends endorsement by the two associations it represents of a program similar to that established in Idaho. The Idaho program provides for an expanded nursing role

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by way of an approval process which requires local professional input and grants statutory protection. The Committee believes that both are necessary ingredients for an expanded nursing role.

*The Idaho Program.* Based upon a mutual physician/nurse effort the Idaho Nursing Practice Act, which is similar to our own Act, was amended as follows (amendment italicized):

"The foregoing (i.e. the definition of the practice of nursing) shall not be deemed to include acts of medical diagnosis or prescription of medical therapeutics or corrective measures, *except as may be authorized by rules and regulations jointly promulgated by the Idaho State Board of Medicine and the Idaho Board of Nursing which shall be implemented by the Idaho Board of Nursing. . . .*"

Procedures implementing the above exception are briefly as follows: Each hospital or physicians' practice desiring to utilize the nurse in an expanded clinical role establishes a committee to determine standard procedures and standards of performance. The hospital committee is composed of representatives from the medical staff, administration and nursing in the special area. The physicians' practice committee is composed of the physician(s) and nurse(s) involved. The standard procedures and standards of performance developed by the appropriate committee must be in writing and include the scope and circumstances under which the nurse in the special area of practice will function as well as information on education or training in the area of practice. The "Standards" and amendments thereto are submitted to the Board of Medicine and Board of Nursing for approval prior to implementation.

*Recommendation.* The Committee on Nursing recommends that the association endorse and support necessary legislation to implement an expanded role for the qualified nurse based upon local needs and desires and approval by the Mississippi State Board of Health and Mississippi Board of Nursing. The Committee serving in its capacity as the MSMA-MNA Joint Practice Committee offers its services in this regard based upon approval by the House of Delegates.

### REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

The report recommends that the association endorse and support necessary legislation to implement and give statutory protection to an expanded role for the qualified nurse based upon local needs and desires and approval by the Mississippi

State Board of Health and Mississippi Board of Nursing. Your reference committee concurs with the intent of this report and recommends that the report be referred to the Council on Legislation for implementation.

The chairman of the reference committee moved adoption of the report.

A substitute motion by Dr. Sam Johnson, seconded by Dr. S. H. McDonnieal, was defeated—"I move that the Supplemental Report A, Council on Medical Service, be returned to the council for further study, such study to include legal opinion regarding questions of ultimate responsibility, effect on present rights under law of physicians to delegate tasks and such other matters as the council may deem pertinent."

The report of the reference committee was adopted.

### REPORT OF THE COUNCIL ON MEDICAL EDUCATION

*Background.* As reported and outlined to the House of Delegates in its *Handbook* (p. 15) your Council on Medical Education has proceeded with formalization of an association sponsored accreditation program for continuing medical education activities within the state. Your Council has been assisted in this effort by a Subcommittee on Continuing Medical Education composed of representatives from the various state specialty societies, the University of Mississippi School of Medicine and the Mississippi Regional Medical Program.

At this time we bring to your attention the actual "Plan of the Mississippi State Medical Association for a Program of Survey for Accreditation of Institutions and Organizations With Continuing Medical Education Programs of Local Scope and Focus" (Attachment A) which we will submit to the AMA Council on Medical Education based upon approval by this House of Delegates. As noted therein the principal objective of our accreditation program will be to document and identify programs of continuing medical education in Mississippi which meet the "AMA Essentials of Approved Programs in Continuing Medical Education."

Also for your information we submit the "Guiding Principles for Continuing Medical Education in Medical Institutions and Organizations" (Attachment B) formulated by the Council and its Subcommittee on Continuing Medical Education Activities after review of other state medical association publications in this regard and AMA certification requirements. These guiding principles were developed to:

1. Assist medical staffs of medical institutions



and organizations in the production of continuing medical education activities;

2. Improve the educational worth and relevance of continuing medical education activities;

3. Outline mechanisms for evaluating the effectiveness of continuing medical education;

4. Provide a basis for the accreditation of continuing medical education activities in medical institutions and organizations; and

5. Outline a plan for the Mississippi Medical Association's Hospital-Medical Survey teams to use in examining the approach of each medical institution and organization medical staff to continuing medical education when such institution or organization desires accreditation of its continuing medical education program.

*Recommendation.* Your Council on Medical Education recommends adoption by this House of Delegates of the proposed "Plan of the Mississippi State Medical Association for a Program of Survey for Accreditation of Institutions and Organizations With Continuing Medical Education of Local Scope and Focus."

*Plan of the Mississippi State Medical Association for a Program of Survey for Accreditation of Institutions and Organizations With Continuing Medical Education Programs of Local Scope and Focus*

This document will serve as an outline for the plan which the Mississippi State Medical Association wishes to plan and implement and will serve as part of that society's application to become an accrediting body for institutions and organizations which provide local continuing medical education programs.

The Mississippi State Medical Association wishes to conduct a voluntary accreditation program within the state of Mississippi for community hospitals and other local institutions and organizations providing continuing education for physicians on hospital staffs and in local communities.

The Mississippi State Medical Association plans to focus its accreditation program, if approved by the AMA Council on Medical Education, upon the following categories of institutions and organizations:

1. Local hospitals which have continuing medical education activities limited to hospital staff and physicians in the local community.

2. Medical organizations which do not have national scope, e.g., county or other local societies.

3. Local units of voluntary health organiza-

tions not under national administration for their continuing medical education.

4. Other organizations and institutions which sponsor or promote continuing education for physicians, essentially local in nature, appropriate to the needs of the profession.

If the Mississippi State Medical Association produces its own continuing medical education program, it would expect to seek accreditation from the AMA Council on Medical Education and would not plan to accredit itself for this activity unless its accrediting body and its programming body (producing CME "courses") are structured totally separately from one another.

The Mississippi State Medical Association is aware of all of the details in the *AMA Essentials of Approved Program in Continuing Medical Education* and expects to use these standards in its own accreditation program. In this way, it will avoid a double standard and will use the same yardstick and guidelines for all local organizations and institutions which it surveys for accreditation.

There are some 160 institutions and organizations present in the state of Mississippi although we cannot, at this time, estimate how many of them now have, or in the future could have, adequate continuing medical education programs.

We shall prepare a list of potential surveyors to be used in our accreditation system. In this list we expect to include hospital directors of medical education, medical school experts in continuing medical education, specialty society experts in this field and voluntary health organization individuals with knowledge and experience in continuing medical education.

We now have an Education Committee with members representing the practicing physician, specialty societies, medical schools, directors of medical education, etc.

We plan to have a budget specifically earmarked for an accreditation program in continuing medical education. Income to provide this budget may come from many sources. Much of it will probably come from fees charged applicant hospitals and other local organizations which desire surveys. Such charges would be designed to cover the actual cost of the surveys and some in-house overhead expenses. Other funds are likely to come from other sources including pharmaceutical firms, educational foundations and the society treasury. Staff assistance will be provided by the existing state society staff initially with possible additions to the staff if necessary, depending upon the volume of surveys in the future.

Our Education Committee will conduct the ac-

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creditation program either directly or through a Subcommittee set up to be a review committee. The Education Committee and the review committee, both, will stand ready to give consultation advice to any hospital or other institution or organization desiring to establish a continuing medical education program based upon accepted Essentials.

The principal objective of our accreditation program will be to document and identify programs of continuing medical education in Mississippi which meet the *Essentials of Approved Program in Continuing Medical Education*. We also believe that, if such accredited programs are based on actual and determined educational needs of physicians, that the quality of medical care in Mississippi can be maintained at a high level.

We will have a mechanism to allow any institution or organization which is dissatisfied with its survey or accreditation action to have a means of appeal through our review committee, Education Committee, and Board of Trustees. Any institution which is denied accreditation shall have the reasons for such non-accreditation provided to it. These reasons in general will also need to conform to the Essentials.

We expect to be in a position to assist other state medical societies if they should wish to set up their own programs of accreditation once we have gained experience in implementing our own program.

While we have no current plans to do so, we can anticipate that some institutions or organizations accredited by our state society, through the Education Committee, will wish to have a certificate, noting that it has been accredited. We expect that we might need to develop such a certificate.

In implementing our accrediting system and prior to carrying out any survey, we would screen the institution or organization, seeking the survey to make certain that it could assure us that it did, indeed, have:

1. Adequate qualified leadership and a strong institutional commitment in favor of continuing education.
2. A written set of objectives to indicate what its continuing education program hopes to accomplish to improve physician competence and patient care.
3. A realistic budget.
4. A competent teaching staff.
5. A curriculum of suitable breadth and depth for the institution's patient mix.
6. Suitable participative educational methods.

7. Adequate facilities for continuing education with suitable audiovisual aids.

8. Some method of audit or quality of care evaluation to determine if the continuing education program for physicians had accomplished its goals.

### REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Your committee reviewed the report of the Council on Medical Education as contained in the House of Delegates *Handbook*. This report recommends adoption by the House of Delegates of a proposed "Plan of the Mississippi State Medical Association for a Program of Survey and Accreditation of Institutions and Organizations With Continuing Medical Education of Local Scope and Focus." We commend this program to the attention of all members and recommend adoption of the Report of the Council on Medical Education.

The report of the reference committee was adopted.

### REPORT OF THE BOARD OF TRUSTEES

*Organization and Duties.* The Board of Trustees is the executive and governing body of the association during vacation of the House of Delegates. It is additionally charged with the duties and responsibilities prescribed by law for directors of corporations. In the discharge of these duties, the Board shall have conducted four meetings during the 1972-73 association year consisting of seven meeting days. Seven officers sit with the Board of Trustees at all meetings. They are the president, president-elect, secretary-treasurer, speaker, vice speaker, and the two AMA delegates.

This annual report includes actions on matters referred to the Board by the House of Delegates and items relating to the management and policy functions which are among the Board's responsibilities.

*Referrals from the House of Delegates.* Matters referred to the Board of Trustees at the 104th Annual Session and actions by the House requiring further actions by the Board include:

- (a) Resolution Nos. 2, 3, and 7. These resolutions concerned the subject of chiropractic and are reported elsewhere in this annual report.
- (b) Resolution No. 4. This resolution urged the employment of a management consultant firm to make a survey of the American Medical Association headquarters. At the June, 1972 AMA Annual Session, Resolution No. 80 was introduced which called for a management consultant firm to make a survey of AMA headquarters.



The resolution was referred to the AMA Council on Long Range Planning and Development.

(c) Resolution No. 5. This resolution commended Mr. Rowland B. Kennedy for his service to the association and recommended recognition of that service by presentation of a plaque and honorary membership in the association. Mr. Kennedy was presented with a plaque by the association president at the March, 1973 meeting of Central Medical Society (the sponsor of Resolution No. 5). A recommended change in the association's constitution and by-laws to grant honorary membership will be before the Council on Constitution and By-Laws at the 105th Annual Session.

(d) Resolution No. 6. This resolution urged statutory protection for the peer review process. Legislation was introduced for this purpose during the 1973 Regular Session of Mississippi Legislature but not acted upon favorably. It should be noted in this regard that Public Law 92-603 (Medicare and Medicaid Amendments of 1972) which was enacted by Congress subsequent to adoption of Resolution No. 6, provides statutory protection for the peer review process when performed under the Professional Standards Review Organization mechanism.

(e) Resolution No. 8. This resolution urged necessary legislation to require insurance coverage for newborn infants. Such legislation was introduced during the 1973 Regular Session of the Mississippi Legislature. It had passed the House of Representatives and was pending in the Senate at the time this report was written.

(f) Resolution No. 9. This resolution directed the Board of Trustees to work with all third party purveyors of medical care to establish information concerning policy changes, values, charges and treatment of patients between them and physicians. The Board has acted to strengthen and improve relationships with third party payors in Mississippi through the MSMA sponsored Mississippi Foundation for Medical Care, Inc., the Physicians' Advisory Committee to the Mississippi Medicaid Commission and the Peer Review Committee. Activities in these several regards are reported elsewhere in this annual report.

*Nominations for the State Board of Health.* No vacancies occurred on the State Board of Health in 1972 and it was therefore unnecessary for the House of Delegates to make nominations to the Governor at the 104th Annual Session. Acting on nominations made in 1971 at the 103rd Annual Session, Governor Waller made the following appointments for six year terms: Public Health District 6, Dr. Joseph G. McKinnon, Hattiesburg; Public Health District 7, Dr. W. Mon-

cure Dabney, Crystal Springs; and Public Health District 8, Dr. Wilfred Q. Cole, Jr., Jackson.

*CHAMPUS.* The association concluded its 16th year as fiscal administrator for CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) in Mississippi. The program continues to grow with an increase in claims volume of 23 per cent and a dollar volume increase of 25 per cent in 1972. A seven-member physician committee serves as the review committee for the program.

*Insurance Programs.* There are approximately 2,600 contracts among 1,350 members in the association's two major group insurance programs. The association sponsors a hospitalization group with Blue Cross and general accident, disability, health and life groups with the Continental Companies. The latter groups are administered by Thomas Yates and Company of Jackson and there are some 1,500 contracts in force. Improvements in these contracts during the year have included a \$100,000 Excess Major Medical Plan, an optional 90-day waiting period under the Disability Income Plan and increases in covered room expenses under the Catastrophe Hospital Plan.

Additionally, the association sponsors a professional liability insurance program with the St. Paul Companies. There are about 1,100 participants in this program. Despite authorized increases in premiums during the year based upon actuarial requirements, the program still enjoys a comparatively low premium rate.

*Budget and Finance.* The Council on Budget and Finance met in November, 1972 and prepared the 1973 budget which was presented to the Board in accordance with established procedure. The budget will be presented to the House of Delegates in the customary manner.

*Legislative Program.* The 1973 Regular Session of the Mississippi Legislature convened in Jackson on January 2, 1973. The Council on Legislation held meetings prior to and during the session for purposes of organizing and monitoring the association's legislative program. Other activities have included production of the weekly legislative newsletter and continuation of the Emergency Medical Care Unit at the Capitol.

The state medical association had a five point legislative program for the 1972 Regular Session, based upon prior action of the House of Delegates: (1) State Medical Examiner Act; (2) health insurance coverage for newborns; (3) legal shelter for peer review; (4) strengthen driver limitation requirements; and (5) prohibit cult of chiropractic from acting as scientific provider of health services. The association also actively supported

## HOUSE OF DELEGATES / Continued

other legislative proposals before the 1973 Legislature. A full report will be made in this regard at the Annual Session.

*MECO.* The Medical Education Community Orientation program consisting of 10 weeks in a hospital environment was approved by the Board of Trustees to continue for the summer of 1973. It was developed as a joint project of the state medical association, state hospital association, and Mississippi chapter of the Student American Medical Association. The students themselves have performed much of the necessary correspondence, administrative work, and all matching of applicants with hospital vacancies.

*Mississippi Foundation for Medical Care.* The Mississippi Foundation for Medical Care was organized in August, 1971 as a wholly-owned, voluntary corporation controlled by the Mississippi State Medical Association. As is true with all medical care foundations, the Mississippi organization has two classifications of membership, administrative and participating.

Administrative members are the Trustees of the state medical association, and in them are vested two important authorities. The Board of Trustees appoints the foundation's Board of Directors, assuring that the will of the medical association extends into every organizational and operational aspect of the foundation. The Trustees may also amend the foundation's By-Laws, another measure of physician control. Participating members are those physicians, either members of the state medical association or who are fully qualified for membership, who voluntarily apply for membership to avail themselves of foundation benefits. No dues are charged for participating membership.

During the past year the foundation addressed itself primarily to organizational activities. Membership doubled so that now over 80 per cent of MSMA members in full-time active practice are members of the foundation.

More recently the foundation has begun study and development of professional fee schedules. Preliminary and informal discussions have been held with the president of Mississippi Hospital and Medical Service (Blue Cross-Blue Shield) concerning upgrading of current contracts to a usual and customary fee basis.

With the passage of Public Law 92-603, medical care foundations will become primary mechanisms for implementation of Professional Standards Review Organizations (PSRO). These organizations may be composed entirely of practicing physicians. They will be responsible for re-

view of all professional services provided under Medicaid and Medicare with respect to the appropriateness of such services when provided on an inpatient basis and the necessity and quality of such services. The PSRO review system will be similar in many respects to the Experimental Medical Care Review Organization (EMCRO) system developed by the association under a grant from the National Center for Health Services Research and Development.

The MFMC will conduct an annual membership meeting in conjunction with the 105th Annual Session.

*Experimental Medical Care Review Organization.* Approximately two years ago, the Mississippi State Medical Association received a grant award of \$369,000 from the National Center for Health Services Research and Development (NCHSRD of HEW) to develop a physician-sponsored system of evaluating the quality of medical care. The funding period is June 30, 1971, through May 31, 1973. The primary goal is to improve the quality of medical care in Mississippi and produce lasting and tangible results.

The first major objective of the EMCRO has been development of a hospital inpatient care review system. This system has involved establishing criteria of care for 70 diagnoses or surgical procedures. Criteria considerations or parameters for selection (criteria tests) include indications for hospital admission, services rendered in the hospital and length of stay. A machine readable coding form has been developed to computer adapt hospital discharge cases for rapid review with computer comparisons to the established criteria of care.

Following computer selection, cases are reviewed first by a nurse (RN) coordinator and then by a reviewing physician under standing orders. The coordinator determines whether a case should be re-entered as normal data or whether a case should be reviewed further by a reviewing physician. The physician evaluates the findings made by the coordinator and determines which cases will be returned to the hospital for further review and follow-up. The hospital should complete the screening cycle by re-checking the cases for any coding errors.

The EMCRO provides each participating hospital with a questionnaire for documenting its review committee's comments and final decision. This information which a completed questionnaire provides can be used by a hospital as a part of its permanent file or as a guide to initiate corrective action. When this information is returned to the EMCRO, it can be used as a type of "feedback" mechanism to assist in refining the criteria,



in revising the input form and in capturing other pertinent information on the case.

The chief educational products of the system are data analyses reports sent monthly to each participating hospital. These reports possess the following characteristics:

(1) Neither patient nor physician are identified other than by code (except upon request).

(2) Reports are printed narrative utilizing spelled out medical terminology.

(3) The reports pertain to the hospital to which sent but compare the hospital to the performance of other hospitals with respect to the criteria of care.

The EMCRO has 35 hospitals participating in its inpatient system. Major activities are refining the criteria, revising the input form and encouraging more physicians and other medical professionals to become more involved in developing the system.

The second major objective of the EMCRO has been development of a hospital emergency room care review system. The development of this system has involved establishing emergency room criteria of care for 20 conditions or diagnoses. A machine readable input form is being developed to computer adapt hospital ER cases for review with computer comparisons to the established criteria of care.

The EMCRO's inpatient and emergency room care review systems are very closely aligned. The goal is to ultimately integrate the two systems so that the entire spectrum of hospital-based care can be reviewed through a single retrospective system.

The third major objective of the EMCRO has been development of a hospital concurrent care review and length of stay monitoring system. This aspect of the overall program was funded by the Mississippi Regional Medical Program as a pilot project for one community hospital over a 14-month period. The basic objective of this system is to monitor care quality as it is being rendered; and also, to monitor length of stay so that an extended stay may be certified as a necessary stay prior to the rendering of the service. This system serves to continuously upgrade the quality of medical care, act as a means of continued education for providers of medical care and at the same time reduce the overall medical cost per patient. This system has relieved the hospital of undesired retrospective denial of payment in services already rendered.

With this system, hospital admissions are assigned a length of stay (PAS—50 per cent) so that the attending physician is aware of this information. A nurse (RN) coordinator monitors the

care following the respective EMCRO criteria and the duration of stay using PAS profiles. Any additional stay has to be certified by some physician other than the attending physician. If there is a difference of opinion between the attending and the review physician, then the hospital's utilization review committee is asked to rule on the unsettled case.

The fourth major objective of the EMCRO is development of a skilled nursing home concurrent care review and length of stay monitoring system. The intent of this system is to extend the same type of concurrent care review and length of stay monitoring for the acute care hospital into skilled nursing facilities.

The procedure will be much the same as that of the acute care hospital with ultimate transfer of patients to different levels of nursing care and/or home health care programs. Review physicians and medical community specialty consultants will serve for both the acute care hospital and the skilled nursing facility. Agreement with one of the ECF's in the state has already been obtained to initiate this program.

MSMA has applied for a third year funding of the EMCRO project. This application for additional funding has been submitted to the NCHSRD of HEW. This year's objectives are:

(1) Continuance of the development of the hospital inpatient care review system.

(2) Continuance of the development of the hospital emergency room care review system.

(3) Continuance of the hospital-based concurrent care review and length of stay monitoring system.

(4) Development of a concurrent care review and length of stay monitoring system for skilled nursing homes.

*Journal MSMA.* The JOURNAL has concluded its 13th consecutive year of continuous publication with the 156th issue in December 1972. It remains the largest single association-sponsored project and is a team effort among the Editors, Committee on Publications, and JOURNAL staff. The thrust of the JOURNAL continues solidly around Mississippi medicine, the association, and the Mississippi physician.

Total pages and advertising pages and revenues decreased from 1971, and printing costs continued to rise. The page numbers were down because of a decrease in the numbers of scientific articles and editorials submitted for publication. Advertising to scientific-editorial ratio increased from the 1971 level, largely because of decrease in the size of the book. The staff has worked with the Ovid Bell Press to achieve every possible economy in the face of rising costs and lowered rev-

## HOUSE OF DELEGATES / Continued

enues, including a change of paper, careful book design, and sparing use of color.

Among the services the JOURNAL contributes to the association by publishing and absorbing costs are: complete program of the 105th Annual Session. Handbook and proceedings of the House of Delegates. Constitution and By-Laws, publication of special issues with reprints, regular listing of component medical society officers and meeting dates.

The Board expresses appreciation to the Editors, committee and staff in the production of this vital membership service.

**MPAC.** The Mississippi Medical Political Action Committee conducted its most active program to date during the past year. We urge continued participation in MPAC and AMPAC by all members.

**MSMA Membership.** At the 104th Annual Session of the association, the House of Delegates took note of a decrease in association membership as reported by the Secretary-Treasurer and urged attention to this matter by appropriate officers of the association. The association's By-Laws charge the president-elect and the three vice-presidents with the responsibility of membership recruitment under the direction of the president. These officers met in Jackson on Oct. 6, 1972. An analysis of the association's annual membership reports for the past several years revealed that a decline in association membership began in 1971, the year the association began making direct billings to members from our central office.

Recognizing the administrative advantages of the direct billing system, your president, president-elect and vice-presidents have acted to establish an annual follow-up system to reach the MSMA member who fails to respond to the direct billing system. Briefly, the system consists of a membership solicitation letter to the former member signed by the president, president-elect and appropriate district vice-president. If no response is received to the solicitation letter, then the appropriate district vice-president arranges for a personal membership solicitation contact to be made. All contact with a former member is coordinated through his component medical society secretary. At the time of this report 34 former MSMA members had rejoined the medical association.

**Organization of the Board.** One new Trustee, Dr. Gerald T. Gable of Hattiesburg, District 7, was welcomed to the Board during 1972-73. Of-

ficers of the Board during the year are Drs. J. T. Davis, Corinth, chairman; James O. Gilmore, Oxford, vice chairman; and Everett H. Crawford, Tylertown, secretary.

### REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee received and reviewed the annual report of our Board of Trustees. We are constantly amazed at the breadth and depth of the Board's many activities in our behalf. We commend these colleagues of ours for their hard work and dedication to this association.

In considering the Report of the Committee on Publications in the Board's annual report, the chairman of the committee, Dr. Lawrence W. Long, brought to the attention of the reference committee a request for members of the association to write scientific articles and editorials for publication in the JOURNAL. Doctor Long also encourages us to seek appropriate local advertising for the JOURNAL. We concur with these recommendations.

The report of the reference committee was adopted.

### SUPPLEMENTAL REPORT A OF THE BOARD OF TRUSTEES

**Legislative Activities—Background.** The 144th session of the Legislature convened in Jackson on January 2, 1973, for the first 90 day session of the 1972-76 Mississippi Legislature. The Council on Legislation held two pre-legislature meetings prior to that date and reported to the Board of Trustees at its December meeting in this regard. The council also met regularly during the legislative session. In accordance with prior mandates of the House of Delegates the council directed weekly publication of the Mississippi Medical Legislative Report and operated an Emergency Medical Care Unit at the Capitol. The latter was supervised by Mrs. Mavis Barlow, R.N., and we are happy to note the adoption of HCR 104 by the Legislature commending and expressing appreciation to the "Doctors-of-the-Day" and Mrs. Barlow for operating the EMCU.

**MSMA 1973 Legislative Program.** For its breadth and depth of proposed medical legislation, the 1973 Regular Session of the Mississippi Legislature had few recent equals. In addition to monitoring all health and medical introductions in the 1973 Legislative Session, the association had a five point legislative program based upon prior actions of the House of Delegates as follows: (1) Establish an Office of State Medical



Examiner; (2) Provide a legal shelter for peer review; (3) Provide health insurance for newborns; (4) Strengthen driver limitation requirements; and (5) Prohibit chiropractors from acting as scientific providers of health services. Based upon policy actions of the Board of Trustees, as recommended by the Council on Legislation, the association also actively supported legislation to: (1) License and regulate ambulance services; (2) Establish a State Department of Mental Health (with strong professional leadership); (3) Require a uniform insurance claim form for physicians' services; (4) Require drug abuse education in public schools; (5) Require osteopath graduates of approved schools to pass same exam as M.D.s for licensure; (6) Provide immunity to hospitals under the implied consent act and (7) Permit hospitals to retire x-rays after seven years.

Bills to provide health insurance for newborns, strengthen driver limitation requirements, regulate chiropractors, provide drug abuse education in public schools, require osteopaths to pass the medical examination, provide immunity to hospitals under implied consent and permit retirement of hospital x-rays after seven years were passed by the 1973 Mississippi Legislature. The bill to provide health insurance for the newborn, although passing the legislature, was vetoed by the Governor last week. Most of those bills which failed to pass this legislative session such as the Medical Examiner Act, the uniform claim requirement, etc., are in final form for introduction in the 1974 Mississippi Legislature. We propose to work with interested groups during the summer and early fall in arriving at support for these various proposals. All will be prefiled for action by the 1974 Legislature. The Board would emphasize again, however, that decisions on legislation are made at home in the representatives' and senators' districts. Our legislative program is only as successful as our efforts on the local level.

*Chiropractic.* At the 104th Annual Session the House of Delegates directed that a positive program be enacted to prohibit chiropractors from acting as scientific providers of health services. This action resulted from the 1972 Regular Session of the Mississippi Legislature wherein it was indicated to the association that just to be "against" licensing and recognition of chiropractors was no longer going to be enough.

The Council on Legislation in an effort to gain some consensus and impression of the members' views on chiropractic, polled all MSMA members last fall with respect to their support or non-support of legislation to license chiropractors and prohibit their (a) advertising (b) using x-ray

and (c) using the title "Dr." You will recall that these were some of the features of the chiropractic bill introduced during the 1972 Regular Session of the Mississippi Legislature. The results of the poll were as follows: Sixty-six per cent of the membership did not respond; twenty-one per cent of the membership were in favor of legislation to license chiropractors as stated in the poll; nineteen per cent of the membership did not want to see chiropractors licensed in any manner for any purpose; and four per cent of the membership gave qualified "Yes" or "No" replies.

Subsequently the council recommended and the Board approved the following association position statement with respect to chiropractic:

Chiropractors should be brought under appropriate state statutes to: (a) prohibit their use of x-ray machines, advertising and the title "Doctor"; (b) require them to pass a basic science exam administered by the State Board of Health or Department of Education (this was in recognition of the fact that no chiropractic school is accredited by any recognized accrediting agency); (c) prohibit their diagnosing and/or treating diseases as defined by the Mississippi Medical Practice Act; (d) prohibit their use and/or prescribing of any drug now or hereafter included in materia medica; and (e) restate their present legal status with respect to ineligibility for hospital staff privileges, payment under health insurance contracts, and Workmen's Compensation.

S.B. 1993 to license chiropractors was passed by the 1973 Mississippi Legislature. The bill, based mainly upon amendments to it in the House which were successfully defended in Conference Committee, contains the following with respect to the requirements noted above: (1) absolutely prohibits newspaper, handbill, etc., advertising by Chiropractors; (2) requires the State Board of Health to promulgate rules and regulations for the use and operation of x-ray machines by Chiropractors; (3) requires Chiropractors to pass a basic science exam in anatomy, physiology and pathology said exam to be approved by the State Health Officer; (4) prohibits Chiropractors from participating under Workmen's Compensation and Medicaid; (5) requires Chiropractors to use no other professional designation except "Chiropractor"; (6) states that chiropractors shall not advise a person to use drugs, prescribe or provide drugs or advise a person not to use a drug prescribed by an M.D.; and (7) prohibits Chiropractors from practicing medicine as defined by the Medical Practice Act.

We had a long, hard and at times dishearten-

(Turn to page 364)

# Radiologic Seminar CXXX: Foreign Bodies in the Esophagus

NADIA A. TYSON, M.D.

Jackson, Mississippi

THE LODGEMENT of opaque foreign bodies in the esophagus is not a very common occurrence. The object has to be sharp or too large to descend. They generally impact at the level of the cervical esophagus at, or above, the inlet. These opaque bodies are often difficult to visualize, when below the pyriform sinus and especially in adults where the laryngeal cartilages are ossified.

Care must be taken in describing the anterior surface of the cervical spine, especially in the presence of spurs, which the attending physician should be aware of in order to prevent injury during the passage of the esophagoscope. Following obtention of the plain films, a small cotton pledget, impregnated with barium, is given for the patient to ingest, as, more often than not, this pledget will be stopped by the foreign body either revealing its presence or confirming it.

This is the case report of a 52-year-old female who was seen in the emergency room, complaining of having a quail bone lodged in her throat. On the plain films of the cervical spine, an ill-defined radioopaque foreign body of osseous density, measuring 8 x 12 mm, was visualized, just anterior to the seventh cervical vertebra and posterior to the trachea. This finding was well in accordance with the history of a swallowed quail bone.

The patient was subsequently given a small cotton pledget impregnated with barium. Under fluoroscopic observation, the barium soaked cot-

ton was noted to hang at the area of the above described foreign body demonstrating a filling defect conforming to the size and configuration of the previously visualized foreign body. A 10 minute follow-up film revealed no change in the position of the pledget. Moderate osteoarthritic changes were noted along the cervical spine at the 5th interspace.

The attending physician was able to remove the foreign body, to which the cotton pledget was still attached, in the operating room under general anesthesia. ★★★

P. O. Box 6597 (39212)



Figure 1. Plain film scout lateral cervical spine.

Sponsored by the Mississippi Radiological Society.  
From the Department of Radiology, St. Dominic-Jackson  
Memorial Hospital, Jackson, Miss.





*Figure 2. Plain film scout lateral C-spine marker on foreign body.*



*3. Fluoroscopic spot film after swallowing cotton pledget.*

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### TIMES DO CHANGE

A couple decided they would like to celebrate their 50th wedding anniversary like their first one. They even rented the same room they had spent their honeymoon night in. As they were getting ready for bed, John went into another room to change. Mary shouted to John, "Will I have time to rinse out my stockings?" John replied, "You'll have time to knit a pair."



# The President Speaking

## “The Profession and PSRO”

ARTHUR A. DERRICK, JR., M.D.

Durant, Mississippi

AFTER LISTENING to innumerable presentations of material at the AMA convention in New York, I made a conscious effort to digest some of it, particularly that pertaining to the institution of the PSRO mandate, already placed on us by our Congress. Resistance to the entire concept was expressed from several quarters, their protestations couched in long-winded generalities. The thought struck me that perhaps one of the reasons for this body of opinion is that besides being an onslaught on our highly-prized sense of independence, of being our own boss, it also presents as a Utopian scheme, impractical and unenforceable. Admittedly, to strive for perfection in any pursuit is a most laudable endeavor, but to expect perfection is a study in frustration. This has been true of the human race ever since Eve bit into that damned apple! But somehow we have managed to survive famine, war and pestilence. I have great confidence in our ability as a profession, guided by able, dedicated men organized voluntarily into the Mississippi Foundation for Medical Care, to survive the strictures of PSRO.

The frantic demands made by some of the delegations for repeal of the whole kaboodle, I fear will fall on ears deafened by the public's clamor for more and ever more from the government. To expect such a turn of events, I fear, would be as fruitless and unrewarding as an attempt to repair a torn hymen, symbolic or otherwise.

Indeed the connotation of the word “professional” assumes a high level of self-imposed dedication and self-obtained competence. This is especially true in our profession. Standards have been set and reset for us over and over again. Hippocrates did it; Moses did it; Osler did it. No wonder we resent the bureaucratic touch!

★★★





## Legal Considerations in Peer Review

"Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret."—Hippocratic Oath.

The self-imposed ethical principle of the medical profession not to disclose information received from patients is restated in the statutes to preserve the confidentiality of physician-patient communications. Peer review activities which involve the examination by other than the physician involved of confidential information in the medical records of patients appears to be in conflict with the principle of confidentiality which surrounds the physician-patient relationship.

This apparent conflict has caused some concern of possible legal liability that might be incurred by physicians involved in peer review activities.

State law decrees that all communications made to a physician by a patient under his charge or by one seeking professional advice are declared to be privileged and the physician cannot be required to disclose such in any legal proceedings except at the instance of the patient. However, hospital records are, by law, decreed to be the property of the various hospitals subject to reasonable access by the patient and attending medical personnel to the information contained therein upon good cause shown.

To avoid giving rise to an actionable invasion

of the patient's privacy on the ground of an unauthorized disclosure by a physician, review activities can be accomplished by using a coding system with no mention of the patient or physician's name and the identity of both generally shielded.

Contrary to the general rule against disclosure, a physician charged with making an unauthorized disclosure of confidential information about his patient cannot be held liable if he was required by law to make such disclosure.

Furthermore, disclosure of confidential information about a patient can be made without fear of liability, if done without malice, and it can be shown that the disclosure was made for certain overriding, competing interests to which the law affords greater protection than to the interest of the patient in keeping the information undisclosed, or the public interest demands for health reasons the disclosure of such information.

Congress has decreed that there is an overriding public interest to be promoted through the mechanism of peer review. The recently passed P.S.R.O. legislation relieves a member of a professional standards review organization from civil liability under any law of any state if he has exercised due care in the performance of any duty, function or activity authorized or required of the professional standards review organization.

The question of liability in the matter of disclosures in connection with peer review activities could be clearly answered if our state would do

as 25 other states have done and adopt a statute to specifically provide protection from liability for the physician, hospital, or person who furnishes medical records for study purposes, and to permit the use of the records and the publication of conclusions reached from gaining basic data through such study. Such statutes prohibit revealing the identity of patients whose records provide part of the study data.

From an overall consideration of the factors having a bearing on the matter of legal liability arising as a result of peer review activities involving the review of confidential information and the medical records of patients, it can be reasonably concluded that peer review activities sanctioned by congress, which necessarily involve the review of confidential information and the medical records of patients, can be accomplished without fear of legal liability, apart from defamation, provided due care has been exercised.

Hopefully, regulations to implement P.S.R.O. legislation will provide supporting basis for the use of confidential information in peer review activities.

CASE AND MONTGOMERY  
Attorneys at Law  
Canton, Miss.

## Some Thoughts For the Future

Two things are of great concern to this writer. The first is inflation. We who are productive and are aware of the necessity of reasonable retirement income may well take alarm at the rapid decline in the buying value of the dollar. While one man can make only a small contribution to this problem and few have time for any active campaign, each in his own way can fight the common and increasingly accepted practice of encouraging the demand for federal funds for every project whether it be for state, civic, or medical community. We can further and perhaps more importantly be aware of and avoid the liberal utilization of hospital and laboratory facilities in federally subsidized patients particularly, supposedly because it is "free." Doctors to some degree, however small, are partly responsible for the inflationary rise in hospital costs.

Secondly, every practicing physician has a primary and selfish interest in the course and trends of medical practice. To withdraw from the

AMA and/or organized medicine may be a form of protest but it has very little impact. All organized medicine as we know it has a democratic structure and each member has a voice, verbally at the local level and through his elected representative at a higher level.

It has never ceased to awe me at the state House of Delegates to watch leaders in medicine sacrifice their time and energy to study problems and attempt solutions that concern each and every practicing physician whether he be a member of organized medicine or not.

The AMA is our national body and controlled by democratically elected representatives. To withhold your support is a protest with minimum impact while to participate can result in an organization with more clout and even more representative of the profession as a whole.

Each can make a significant contribution by trying to curtail medical costs to a minimum that is still in keeping with sound and good medical practice. The cost of medical attention is the biggest factor in federal intervention of private practice.

Secondly, each can contribute by encouraging new members to join the organized forces.

W. MONCURE DABNEY, M.D., Editor  
Crystal Springs







### Book Reviews

**Gastroscope With the Fiberscope: Principles, Technique and Diagnostic Possibilities.** By G. Allegra, M. Macchini and F. Andreoli, 154 pages with illustrations. Padua, Italy: Piccin Medical Books, 1971. \$15.00.

This book deals with the endoscopic view which has always been fascinating and mysterious. I started to read it with enthusiasm because endoscopy provides the unique opportunity to view the interior hollow organs or entire organic system with minimal or non-surgical trauma. However, from the first chapter it was apparent that this book was much behind the modern endoscopy.

The first chapter of this book, 51 pages (one third), deals with the theoretical basis for modern gastroscopic methods, but only mentioned old and obsolete instruments. Specifically Hirchowitz I and II gastroscopes exclusively; which were undoubtedly of tremendous advances in pioneering fiberoptic gastroscopy but are not generally used any more at present in this country since the methods advised for doing the procedure are unnecessary and cumbersome like requesting as preparation for endoscopy to have the patient on a 24-hour liquid diet. Also, the positions of the patient for the procedure are complicated, impractical. The authors especially do not mention the one position which is generally used in 99 per cent of the cases, the left lateral.

In the chapter on "practical value of gastroscopy," the authors emphatically stated that "radiology must always be performed before endoscopy" which is contrary to what everybody practices in cases of acute upper G.I. bleeding where the contrary is the routine. Later on, the book contradicts the statement when it says "that is the sole emergency diagnostic procedure in cases of hematemesis and melena." The second part (74 pages) is much more interesting because of some unusual cases. The endoscopic photographs are of poor quality related probably to poor illumination sources of the early instruments. However, the correlation with x-ray films and photographs of the anatomical specimen is good. The foreign body chapter is again obsolete because many of the cases presented, if not all, could have been solved today by endoscopy alone (extraction of

the foreign bodies) without surgery.

In summary it could be said that this book was born four or five years too late about a very dynamic and changing subject and relating what has been achieved in the last few years in gastrointestinal endoscopy due to introduction of fiberoptic scopes emerging as an increasingly important diagnostic technique in clinical and research gastroenterology was not accomplished in this book.

LIDIO O. MORA, M.D., Jackson, Miss.

**Principles of Clinical Electrocardiography, 8th Edition.** By M. J. Goldman, M.D. 400 pages with illustrations. Los Altos, Calif.: Lange Medical Publications, 1973. \$8.00.

Any book in its eighth edition and available in six languages must be classified as a classic in its field, and Doctor Goldman's book is such a classic. The latest edition retains the size and format of earlier versions and is characterized by concise text and numerous illustrative tracings and large, clearly drawn diagrams. It covers electrocardiography from intracellular potentials to the latest concepts of intraventricular conduction defects, and does so in a way for the most part uncontroversial. Its organization is along more or less traditional lines and generally can be understood easily; its thrust is to present mostly facts in a thinly outlined reference frame of principles.

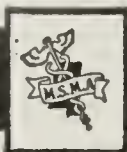
There are word problems, as when unipolar leads are contrasted with vectorial analysis, a non-sequitur, and there is a tendency to refer to vectors as things in themselves rather than as a means of expressing concepts. The continued use of the idea of the heart's rotating on its various axes is a bit surprising since this generally has not been used by other authors since Goldberger's works of the 40's. The mean frontal QRS axis is estimated more closely than most would agree is useful, but the fact that there are different approaches to this problem is at least indicated. The most serious shortcoming of the book is that the reading lists suggested at the end are not referred to in the text; the result is that they are approximately useless and that none of the statements in the text is documented. The overall effect is a bit too dogmatic and arbitrary.

The book is more likely to be useful for electrocardiographers who would like to know what one with Doctor Goldman's experience thinks about

## THE LITERATURE / Continued

things than for beginning students of the subject. For the former it is a good source of the up-to-date views of an experienced worker in the field; for the latter it is too thick and offers no leads to the literature for explanation of the author's opinions or discussion of different views.

THOMAS M. BLAKE, M.D., Jackson, Miss.



## DEATHS

HENDRICK, RICHARD G., Okolona. M.D., University of Tennessee, Memphis, Tenn., 1950; interned one year, John Gaston Hospital, Memphis, Tenn., 1950-51; died May 19, 1973, age 48.

SCOTT, WALTER W., Jackson. M.D., Vanderbilt University, Nashville, Tenn., 1915; died June 15, 1973, age 86.



## PERSONALS

FRANK M. ACREE of Greenville has been awarded a Certificate of Merit honoring his 50 years in the active practice of medicine as an alumnus of the University of Tennessee Medical School. The award was made at this year's graduation exercises in Memphis.

O. J. ANDY and BERNARD S. PATRICK of Jackson and UMC attended the Bermuda convention of the Neurosurgical Society of America.

RICHARD BORONOW of Jackson and UMC met with the American Cancer Society clinical fellowship committee in Miami in June.

WALTER BOURLAND and JOHN BOWLIN of Tupelo were guest speakers at the 38th annual state convention of the Mississippi Association of Nurse-Anesthetists held in Tupelo. Dr. Bourland discussed Caesarean sections and Dr. Bowlin spoke on implantation of a pacemaker.

LEONARD H. BRANDON of Starkville and JAMES E. BOOTH of Eupora are serving as Region Seven

commissioners of the Mental Health-Mental Retardation Commission.

MARION H. BROWN, DAVID B. JOHNSON, NANCY C. LAWHON and WILLIAM S. POLLARD are serving as fulltime emergency room physicians for St. Dominic Hospital in Jackson.

RICHARD H. CLARK of Hattiesburg was guest speaker at the first meeting of the Northeast Mississippi Health Planning Council's emergency medical service planning committee held in Tupelo. Dr. Clark discussed emergency care systems.

ROBERT S. COOK, JR., of Hattiesburg was guest speaker at the second annual graduation of medical technologists at the University of Southern Mississippi.

HUGH B. COTTRELL of Jackson was honored upon his retirement as State Health Officer with a reception at the State Board of Health. Dr. Cottrell has more than 40 years of service in the public health field, the last five as State Health Officer.

ARTHUR A. DERRICK, JR., of Durant, MSMA president, was honored with a reception at McMorrough Library on the Holmes Junior College campus in Goodman. The event was sponsored by the Durant Chamber of Commerce with Holmes County physicians and their wives serving as co-hosts.

W. M. FLOWERS, JR., of Jackson and UMC attended the 10th annual meeting of the Society of Nuclear Medicine in Miami.

HANNELORE H. GILES and CONRAD HORECKY, III, of Hattiesburg have opened their new offices at the corner of 28th Avenue and McInnis Street.

WILLIAM GODFREY of Natchez addressed members of the District I Nurses Association on the abortion laws and the Supreme Court decision.

JAMES R. GREEN has associated with the Hattiesburg Clinic Professional Association, 415 S. 28th Avenue, for the practice of orthopedic surgery. Dr. Green completed his residency at the University Medical Center June 30.

JOSEPH C. HILLMAN has associated with DAVID H. STRONG and FRANK C. MASSENGILL at 203 W. Congress Street in Brookhaven for the family practice of medicine. Dr. Hillman recently completed his internship at the University Medical Center in Jackson.



THOMAS E. HOLDEN has associated with CHARLES M. HEAD and WILLIAM H. GOODLOE, JR., at Lakeland Clinic for Women in Jackson. Dr. Holden just completed his residency in obstetrics and gynecology at the medical center.

VERNER S. HOLMES of McComb has been named to head the Medical Education Committee of the Board of Trustees of State Institutions of Higher Learning.

LLOYD G. HOPKINS of Oxford was chosen secretary of the Mississippi Heart Association at the annual meeting in Biloxi. WILLIAM L. WOOD, JR., of Tupelo was named president-elect.

HUGH JOHNSON of Vicksburg spoke on "Medicine in the Civil War" at the monthly meeting of the Jackson Civil War Roundtable in Jackson.

ALBERT H. LAWS has associated with FRANCIS E. MCCULLOUGH and WILLIAM R. ARMSTRONG at 955 North State Street in Jackson for the practice of diseases and surgery of the eye.

T. F. PUCKETT, J. L. SMITH, R. S. COOKE, JR., and J. F. RUDE of Hattiesburg have moved to their new pathology laboratory at No. 1 Medical Boulevard.

JACK STOKES of Pontotoc and RUBY GRIFFIN of Calhoun City have been appointed to the new Northeast Mississippi Health Planning Council eight-county Emergency Medical Service Committee.

F. E. TATUM of Hattiesburg was presented the Silver Distinguished Service Award for his contributions in heart volunteer service work at the annual awards dinner of the Mississippi Heart Association. Dr. Tatum currently serves on the MHA board of directors.

KERMIT TILL of Jackson announces the association of DEAN R. MCMILLAN in the practice of family medicine at 1065 Pecan Park Circle.

A. RANDLE WHITE has associated with LEON LENOIR, JR., and ROBERT E. LEE of Greenville for the practice of internal medicine at 1307 East Union Street.

DAVID B. WILSON of Jackson and UMC met as a member of the Joint Commission on Accreditation of Hospitals standards committee in Chicago.

JOHN D. WOFFORD of Greenwood has been named to the Millsaps College Board of Trustees for a six year term.

GARY P. WOOD of Jackson and UMC has received a research grant from Southern Medical Association for his project on Comparison of Histological and Estrogen Binding Characteristics of Uterine Leiomyomata (human).

## UMC Starts Summer Enrichment Program

A first-year summer enrichment program in the University of Mississippi School of Medicine is giving 16 black students supplementary preparation for medical school this year.

Planned by the Medical Center minority student affairs office, the project offers premedical instruction in anatomy, physiology and biochemistry. Minority student affairs coordinator Peter Stewart explained that these are the areas most cited by students from predominately black colleges that need additional reinforcement for medical school.

Participants will also preview medical terminology, the relationship of basic science to medicine and clinical experience.

Eight of the students will enter the School of Medicine as freshmen in September, while eight are still in collegiate premedical studies at the senior level.

Need for the new summer enrichment program, said Stewart, stems from the state's drastic lack of health professionals, particularly from Mississippi's minority groups. Less than three per cent of the licensed physicians in Mississippi are black, he added.

Evidence shows that minority individuals, including blacks, Indians, Chinese and Mexican-Americans, tend to practice in the country's physician-shortage areas, as well as women and those from rural backgrounds.

Studies also show, Stewart pointed out, that medical schools lose more minority students during the freshman year than in subsequent years. With each successive year successfully completed, the student's chances of completing medical school go up.

The 10-week program draws from both School of Medicine faculty and student teachers at or above the sophomore level in medical school.



# Woman's Auxiliary to the Mississippi State Medical Association

## FIFTY YEARS OLD . . . and we admit it!

In 1922 the Woman's Auxiliary to the AMA was officially begun. Just one year later on May 9, 1923, at the annual state medical meeting in Vicksburg, 22 doctor's wives founded the Woman's Auxiliary to the Mississippi State Medical Association. Dr. T. M. Dye, then secretary of the MSMA, presided over the meeting until the little organization elected officers. We were privileged to honor three of the charter members at the WA/MSMA Fifty-Year Gala Luncheon in Biloxi this past May: Mrs. Augustus Street, Mrs. W. H. Parsons and Mrs. H. H. Haralson, all of Vicksburg. It was great fun to hear their recollections of those early days.

These visionary women in Vicksburg knew that the fellowship among doctors' wives was unique and meaningful and desired initially to cultivate this relationship. They were also thinking about their doctor husbands and how they could develop a helpmate organization for their wonderful profession of service.

The early history of the Mississippi Auxiliary reflects a continuing effort to stress friendship and understanding between lay and medical members of the community, with doctors' wives sharing actively in projects that fostered a better relationship.

Throughout the 50 years from 1923 to 1973 Mississippi doctors' wives have supported and participated in activities concerned with health education and related health services. They have supported AMA-ERF, Doctors' Day, research and romance of medicine, safety and disaster preparedness, mental health and health careers. In recent years they have recognized, along with their husbands, the importance of medical and health legislation, and have broadened their understanding by participating in programs related to international health.

In 1973 there are 22 unit auxiliaries in our state and membership has grown to approximately 1,000 members.

We would like to remind you that we are still your helpmate organization. We are eager to know how we can help to keep our Mississippi people well in body and strong in mind and spirit.

This year, as we celebrate our GOLDEN ANNIVERSARY, we feel that it is a wonderful privilege to be a doctor's wife and that there is no demand upon our time more worthy—or more exciting—than working with our husbands to build and keep a healthy nation. That's why we chose the theme: MY PRIORITY: DOCTOR'S WIFE.

We still want to strengthen the fellowship between doctors' wives. We are especially concerned about the critical shortages of medical and allied health personnel. Along with WA/AMA we are interested in the current needs of nutrition, safety and children and youth.

*(Turn to page 381)*





# Mississippi Academy of Family Physicians Elects Officers and Holds Annual Meeting

Dr. William Bernard Hunt of Grenada was inaugurated as president of the Mississippi Academy of Family Physicians at the 25th Annual Scientific Assembly held July 11-14 in Biloxi.

Dr. Thomas J. Anderson of Laurel, former vice president, was elected president-elect. Immediate past president is Dr. Eugene F. Webb of Itta Bena.

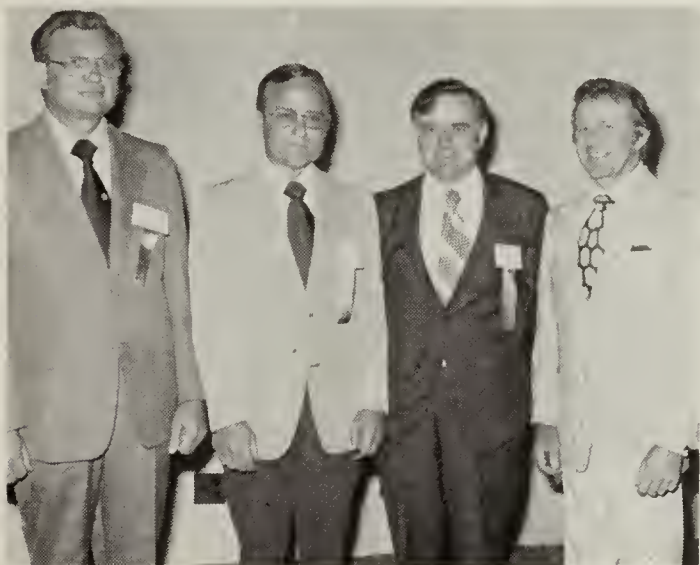
Other officers elected were: Dr. Richard T. Furr of Ocean Springs, vice president, and Dr. Marion L. Sigrest of Yazoo City, secretary-treasurer.

Dr. Charles R. Jenkins of Laurel was re-elected to another two-year term as delegate to AAFP. Dr. John B. Howell of Canton will be serving the second year of his two-year term. Dr. A. T. Tatum of Petal was re-elected alternate delegate for a two-year term, and Dr. Joe E. Johnston of Mount Olive will be serving the second year of his term.

Members of the Board of Directors for five of the 10 districts came up for re-election to two-



*Three years of the academy's presidency are shown at the annual convention. From left are Dr. William B. Hunt of Grenada, president; Dr. Eugene F. Webb of Itta Bena, immediate past president; and Dr. Thomas J. Anderson of Laurel, president-elect.*



*New officers elected by the Mississippi Academy of Family Physicians are from left: Drs. Thomas J. Anderson of Laurel, president-elect; William B. Hunt of Grenada, president; Richard T. Furr of Ocean Springs, vice president; and Marion L. Sigrest of Yazoo City, secretary-treasurer.*

year terms. The new directors are: Dr. Ben Kitchens of Ocean Springs—District I; Dr. Frank C. Massengill of Brookhaven—District III; Dr. William M. Gillespie of Meridian—District V; Dr. Walter H. Rose of Indianola—District VII; Dr. James O. Gilmore of Oxford—District IX. Other directors serving the second year of their terms are: Dr. W. Boyce White of Laurel—District II; Dr. Robert E. Jennings of Taylorsville—District IV; Dr. Arthur E. Wood, Jr., of Belzoni—District VI; Dr. Richard L. George of Columbus—District VIII, and Dr. Jack A. Stokes of Pontotoc—District X.

New officers were installed by Dr. John B. Howell of Canton at the banquet on Friday evening.

Scientific programs by guest lecturers on acupuncture, orthopedics, oral contraceptives, shock, rheumatoid arthritis, office cancer chemotherapy, and hyperlipidemia highlighted the meeting. Outstanding speakers included Dr. William C. North of Memphis; Dr. Stewart L. Nunn of Memphis; and Dr. Colon H. Wilson of Emory University.

## Six State M.D.s Inducted by ACP

Six Mississippi physicians were among a total of 315 physicians in the United States and Canada who have been made Fellows of the 57-year-old American College of Physicians (ACP) which represents specialists in internal medicine and related fields.

The new Fellows of the American College of Physicians from Mississippi are Drs. Kenneth R. Bennett, John D. Bower, Bernard J. Dreiling, William R. Lockwood, William M. McKell, Jr., and Robert E. Tyson, all of Jackson.

Dr. Walter B. Frommeyer, Jr., Birmingham, Ala., president of the American College of Physicians and Distinguished Professor at the University of Alabama School of Medicine, said the new fellows have earned the Fellowship honors through scientific accomplishments and by acceptance as leaders in their specialties as determined by fellow practitioners.

The 23,000-member American College of Physicians dedicates itself to up-grading medical care, teaching and research through stringent membership requirements and programs of continuing education. It was the first medical specialty society to offer periodic self-assessment examinations to physicians (enabling some 30,000 practitioners to judge for themselves their own degree of competence in specific medical areas—and thus plan their need for postgraduate educational programs.)

College officers, who will serve until the 55th Annual Session in New York, N. Y., April 1-5, 1974 (in addition to President Frommeyer) are president-elect Dr. Truman G. Schnabel, Jr., Philadelphia, Pa.; and vice president, Dr. John A. Layne, Great Falls, Mont. Serving five-year terms are treasurer, Dr. William F. T. Kellow, Philadelphia, Pa. and secretary-general, Dr. Carmichael Tilghman, Baltimore, Md. Dr. Edward C. Rosenow, Jr., Philadelphia, Pa., is ACP executive vice president.

## Dr. Morris Receives 50 Year Club Pin

Dr. Lawrence Boling Morris of Macon was presented the 50 Year Club Certificate and Pin of

the Mississippi State Medical Association at the June meeting of the Prairie Medical Society held in Columbus.

Dr. Arthur E. Brown of Columbus, MSMA past president and AMA alternate delegate, made the presentation.

Membership in the exclusive 50 Year Club of the association is granted after a physician has practiced medicine for 50 years and he is recommended for the honor by his local medical society.

Dr. Morris attended the University of Mississippi and received his B.Sc. degree from Mississippi College. He earned the M.D. degree from Northwestern University in Chicago in 1922 and interned 1922-23 at Ancon Hospital in the Panama Canal Zone.

Dr. Morris practices family medicine and general surgery in Macon. He is a Fellow of the American College of Surgeons and a member of the American Medical Association and the Southern Medical Association. In 1967 he served as president of the Prairie Medical Society.



*Dr. Lawrence Boling Morris of Macon, left, is presented the Mississippi State Medical Association 50 Year Club Pin and Certificate by Dr. Arthur E. Brown of Columbus at the June meeting of the Prairie Medical Society.*



## Tree of Hippocrates Presented to MSMA

Sam L. Brent, Schering District Manager, has presented to the Mississippi State Medical Association a young tree grown from a seed of the great Tree of Hippocrates, found on the Greek Island of Cos. Dr. James P. Spell, Secretary-Treasurer, and Charles L. Mathews, Executive Secretary, accepted the tree for MSMA.



*Mr. Sam L. Brent, center, of Birmingham, Ala., Schering District manager, presents a sapling from the historic Tree of Hippocrates to MSMA Secretary-Treasurer, Dr. James P. Spell, left, and Mr. Charles L. Mathews, the association's Executive Secretary.*

The tree donated by Schering Corporation was one of those purchased by the international pharmaceutical firm for distribution to medical schools and teaching hospitals throughout the United States. The company purchased the trees to provide funding for a widespread knowledge of the Medical Foundation of Cos which is supported, in part, by sales of the trees.

The Tree of Hippocrates grows on the Greek Island of Cos and is reputed to be over 2400 years old. Its huge ancient branches are supported by wooden and granite pillars. Each year the giant tree, said to be a plane or sycamore tree sheds thousands of tiny seeds. Attempts in the past to grow trees from these seeds failed because there was no way to distinguish viable from unviable seeds. A soft X-ray technique developed by Dr. William Gibson of the University of Vancouver, British Columbia, provided the first efficient means of making the determination. As a result, Dr. Gibson and his associates at the Uni-

versity of Vancouver have grown thousands of trees from the Great Tree of Hippocrates with success.

Dr. Gibson and his medical colleagues in Canada, Greece and the United States are seeking to build an international medical foundation on the Island of Cos where Hippocrates, the father of modern medicine, is said to have lived and taught his students.

## Multiple Sclerosis Award Announced

The National Multiple Sclerosis Society announces the establishment of the Ralph I. Straus Award. This award, in the amount of \$100,000, will be given to that scientist or those scientists of any nationality whose published research shall be judged to have resulted in the development of effective and specific methods for preventing or arresting multiple sclerosis.

Mr. Straus has stated that "the intent of this award is to speed the conquest of multiple sclerosis through the enhancement in a realistic manner of the needed awareness of the vast social values inherent in the conduct of research in the biomedical sciences."

The funds of the award will be managed by the National Multiple Sclerosis Society of the United States. The recipient or recipients of this award will be determined by an independent Ralph I. Straus Award Committee to be appointed by the society. The award committee is to be comprised of distinguished scientists in such fields as neurology, immunology, neuropathology, biological chemistry, experimental pathology and microbiology.

Members of the award committee will not be eligible for this award, and no member can serve on the committee when a nominee being considered for the award is a member of his or her own institution.

The members of the award committee will be named and the committee will meet following receipt by the National Multiple Sclerosis Society of a fully documented nomination(s) for the award, which nomination(s) has been approved by the majority of the members of the Medical Advisory Board of the society.

## Dr. Longest Improves MSU Pre-Med Program

Doctors and railroads may seem like a funny combination to some people. But Dr. John Longest, director of the Student Health Center at Mississippi State University, thinks it's one of the most natural combinations in the world.

Dr. Longest, who was born in Columbia and reared on the Gulf Coast, is in his 25th year as director of the health center and university physician.

He is one of the four MSU Alumni Association Award winners for 1972-73, receiving his award in the field of distinguished service.

His fascination with railroads began in childhood, but paid off in 1966 when the tracks of the old GM&O Railroad were removed from the MSU campus after three-quarters of a century. Upon his request 4,000 of the spikes from the tracks were given to the MSU Medical Alumni Association which Dr. Longest helped organize.

The spikes were plated, marked with an MSU "M", and mounted. They were offered to alumni and friends of the university who would contribute \$100 or more to the C. B. Mitchell Pre-Med Fund. Thus far more than \$39,000 has been received from this source.

The fund serves as a tribute to the late Dr. Charles B. Mitchell who served as university physician for 27 years.

"The whole purpose of the money we have collected from the spikes is to improve pre-medical education at Mississippi State," he said. "The ultimate goal of the alumni is to endow a Distinguished Chair in Pre-Med at MSU. The C. B. Mitchell Lectures are offered to stimulate the pre-med students and inform the university community."

Four lectures have already been presented. The first lecturer was Dr. Alton Ochsner, director of surgery at the Ochsner Clinic and Ochsner Foundation Hospital in New Orleans and former president of the American Cancer Society. In his series of lectures on the hazards of tobacco, he spoke to more than 10,000 MSU, MSCW, and high school students, as well as area residents.

The second distinguished lecturer was Dr. Louis Z. Cooper, assistant professor of pediatrics at the New York University School of Medicine. Dr. Cooper's topic was "Rubella: A Preventable Cause of Birth Defects." While here, he also tested 4,000 ladies of childbearing age for sus-

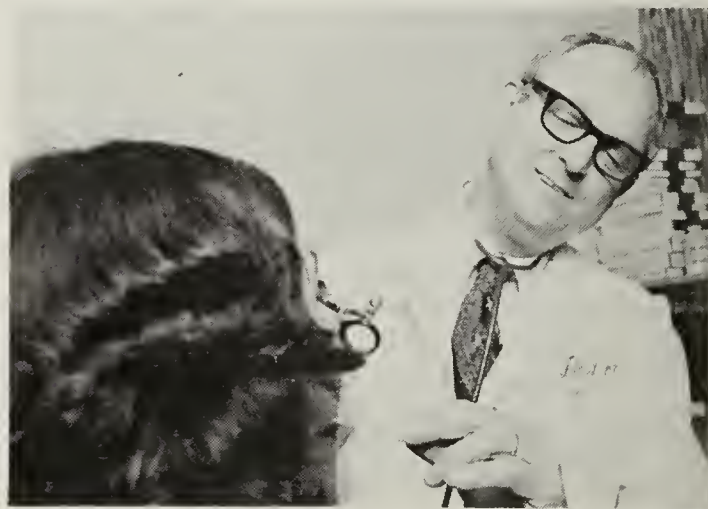
ceptibility to rubella or German measles.

The third lecture was a symposium on narcotics and dangerous drugs by Dr. Donald Louria, chairman of the Department of Public Health and Preventive Medicine at the New Jersey College of Medicine and Dentistry. He spoke on "The Drug Scene." A panel of speakers included Dr. Carl Hester of Tuskegee, Ala.; Dr. William Jaquith, director of the state hospital at Whitfield; and Dr. Norman Doorenbos, chairman of the Department of Pharmacognosy at the University of Mississippi.

Last year's program was a lecture on medical education in the United States by Dr. James W. Ward. Dr. Ward is chairman of the Department of Anatomy at the University of South Florida School of Medicine in Tampa, and former professor of pre-med at MSU.

Dr. Longest says national attention has been brought to the school because the MSU student health center treats not only students, but their dependents, plus faculty and staff families.

"Because of pending legislation in Congress dealing with health maintenance organizations, a lot of other physicians are interested in our program here," said Dr. Longest.



*Dr. John Longest, director of the Student Health Center at Mississippi State University for 25 years, is one of four winners of the MSU Alumni Association Award.*

Dr. Longest and his associate Dr. William C. Welch believe in the use of nurse practitioners and other paramedical personnel to care for many ailments. Together they attend over 40,000 student visits to the clinic each year. They do not view their practice only as adolescent medicine, but rather in terms of developing healthy and happy adults.

"The charts show the college age group is a low risk group in terms of serious health prob-



lems," he said. "They are past childhood diseases and except for chronic illnesses such as congenital defects, diabetes, and asthma, many will pass the time free of serious disease. It is important that we teach them good health habits, as preventive medicine against what may happen later in their lives as a result of the hazards of environment, occupations, or advancing age. This can greatly modify each one's medical destiny to obtain a 'survival advantage.' "

Dr. Longest is a member of the American Medical Association and is chairman of the Committee on College Health of the Mississippi State Medical Association. He is a former director and past president of the Mississippi Academy of Family Practice, a former director of the Mississippi Heart Association and the Easter Seal Society. He is a member of the Board of Directors of the National Interagency Council on Smoking and Health representing the American College Health Association.

## Antiserum at Emory Screens for Leukemia

A substance developed at Emory University is being used to screen apparently healthy individuals for early signs of leukemia and similar forms of cancer.

Dr. Daniel Rudman, professor of medicine and director of the Emory University Clinical Research Facility, identified the substance as an extremely sensitive antiserum made by injecting a unique protein found in leukemia patients into live rabbits.

He emphasized that the screening tests are still experimental but eventually it is hoped that large population groups can be tested with specific antisera for various forms of cancer.

The active molecule in the antiserum is an antibody specifically tailored in the rabbit's body to enable the animal to reject the abnormal or foreign protein which is produced during metabolism of human cancer cells. The antiserum's antibody forms a visible reaction with even a minute quantity of the cancer-related protein.

About 80 per cent of leukemic patients show a positive reaction with the antiserum, Dr. Rudman said. In addition, about 60 seemingly normal individuals, with no symptoms of cancer, have been tested with leukemia antiserum in the NIH-supported Emory University Clinical Research Facility at Emory University Hospital. Of these, three have shown positive reactions.

Dr. Rudman said that even though the three

test subjects with positive reactions are symptom-free, they will be examined regularly for a number of years to see if leukemia or any other cancer develops. "We'd like to know if we've found some form of cancer in a very early pre-symptom stage in these people," he explained.

The research project is based on the discovery at Emory and at other medical centers that many cancers produce abnormal proteins specific to that particular type of cancer. The cancer cells release the proteins into the body fluids such as blood and urine. The cancer-related proteins also appear in fluid collections which may form in the cavities of the abdomen or chest.

The Emory group is working with three such proteins which appear specific for the following types of cancers: leukemia and leukemia-related diseases, including Hodgkin's disease and the lymphomas; cancer of the gastrointestinal tract; and cancer of the breast.

So far, the most sensitive type of antiserum has been produced with the leukemia-related protein.

"There is evidence that as many as 15 different cancer-related proteins may exist," Dr. Rudman said. "We've isolated three of these and developed a potent antiserum to one. But once each protein is isolated, it's only a matter of time before an antiserum is made."

The work is similar to efforts in a number of medical centers to develop mass-screening based on a protein called carcinoembryonic antigen (CEM), which seems specific for cancer of the lower bowel, Dr. Rudman said. CEM is taken from the tumor itself, while Dr. Rudman and his colleagues are working with proteins isolated from body fluids.

It is believed the cancer-related protein molecules being studied at Emory are "throwbacks" to a type of material produced at an earlier stage of development before the cell differentiated into a mature adult cell type.

In other cases, the abnormal protein may be shed from the abnormal surface of the cancer cell, Dr. Rudman said.

The research has possible applications in mass screening for various types of cancer in large population groups, the Emory physician said. Only one drop of a person's urine or blood plasma is required for the antiserum test.

In addition, these investigations provide useful information about the biology of the cancer cell itself, particularly regarding the structure, properties, and origin of the cancer-related proteins.

The project has received a grant of \$41,000 from the National Cancer Institute for the current year.

## X-Ray Standard Date Extended

The Food and Drug Administration has extended for a year the effective date of a federal radiation protection standard for new diagnostic x-ray equipment, but warned manufacturers that no further extension will be granted. The date was changed from Aug. 15, 1973, to Aug. 1, 1974, in a notice published in the *Federal Register* of June 12, 1973.

The action followed requests for more time to comply with the standard from public radiation control agencies and representatives of industry, medical and dental x-ray equipment users.

Sixteen of 18 state and local radiation control agencies submitted letters in support of the extension. Some said they needed more time to obtain instrumentation to test x-ray machines for compliance with the standard. Others said they required time to revise state x-ray equipment regulations and develop procedures for enforcement of the standard.

Manufacturers said they needed additional time to redesign and redevelop equipment to meet the radiation protection performance requirements of the standard; obtain suitable components and parts from suppliers; prepare instructions for assemblers and users of x-ray equipment; train assemblers; and develop equipment testing and quality control programs.

One hundred and thirty-four catalog items could not be certified as complying with the standard by Aug. 15, 1973, industry representatives said. This would mean, according to manufacturers' estimates based on normal sales, that about 4,500 x-ray components and subsystems and 1,400 complete units would have been withheld from the market as not meeting the standard had the Aug. 15 effective date been retained. Such shortages, FDA said, might have had "an adverse impact" on the delivery of medical care.

One of the principal patient protection provisions of the standard requires machines to be capable of restricting the x-ray beam to the size of the film or fluoroscopic image receptor. The standard also contains provisions intended to make it possible for operators to reproduce more consistently a given image quality for given voltage, current, and time settings. This capability, in combination with good x-ray examination techniques, will tend to minimize film retakes and unnecessary exposure.

FDA emphasized that most x-ray machines now in use meet state radiation control regulations or national voluntary standards.

# Rondomycin<sup>®</sup>

## (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE:** **Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. **Gonorrhea:** In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days

**SUPPLIED:** 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



WALLACE PHARMACEUTICALS  
CRANBURY, NEW JERSEY 08512



# Miss Louise Williams Retires as S.B.H. Librarian

Miss E. Louise Williams retired as librarian of the Mississippi State Board of Health Library, July 31, 1973, after 37 years of service. Except



Miss Williams

for a year as cataloger and reference assistant at Rudolph Matas Medical Library at Tulane, 1952-53, her main effort has been upon the development of a library to serve the health professions of Mississippi. This library, the first in the state to provide such assistance, has been a key source of reference help to physicians and others, lending

its journals and books statewide. Literature searches and bibliographies are also provided.

The Mississippi State Medical Association has cooperated in the development of the library, providing it with its exchange journals. This with the assistance received through the Medical Library Association Exchange has enabled Miss Williams to build an excellent collection on a very small budget allocated by the state.

Upon discovering that the *Mississippi Doctor* (predecessor to JMSMA) was not being indexed in the important *Quarterly Cumulative Index Medicus*, Miss Williams got in touch with the publisher, the American Medical Association, after communicating with Dr. W. H. Anderson, editor of the Mississippi journal, offering assistance in preparing an annual index if he would use continuous pagination for each volume. The AMA cooperated and included it in QCIM and detailed annual indexes were prepared by Miss Williams for volumes 16-36 (1938-1959) in partial reciprocation for exchange journals. The indexes have been of much help in locating material wanted from these early volumes, a bound file of which is available in the library. There is also a complete file of the Mississippi State Medical Association Transactions, the *Mississippi Medical Journal* v.3 (1899-1900), the *Mississippi Medical Record* (1900-04) and *Mississippi Medical Monthly*, v.1-19 (1897-1914)—the latter two being incomplete.

The library contains a good cross-section of the medical, public health and allied scientific litera-

ture published in the English language in the 19th and 20th centuries, including many Garrison-Morton classics, according to Miss Williams. The important bibliographical tools are available, beginning with the *Index Catalogue* up to the latest issue of *Index Medicus*, enabling the librarian to bring borrowers a thorough search of what has been published on any topic on which help may be needed. "To date, nothing has replaced the well-organized medical library either as a readily accessible repository of knowledge or as a reliable resource for continuing education." The paramount concern of the library is that it contain the material that will best support the goals of the public health program and will assist others in promoting the health care of all people.

Reflecting upon the accomplishments of these years, Miss Williams states, "It has been a great experience to have had a part in developing a useful collection in the health sciences field and it has been an exciting era in the advancement of technologies which strengthened the functions and goals of libraries everywhere. I count myself fortunate to have been a part of this era. It was a rich experience to work and grow with others in professional endeavors, especially the Medical Library Association, which brought friendships from almost every state and continent. I look forward with great anticipation of good things for the future and in keeping in touch."

## Chest Physicians Plan Annual Assembly

The 39th Annual Scientific Assembly of the American College of Chest Physicians will be held Oct. 21-25 at the Four Seasons Sheraton Hotel, Toronto, Ontario, Canada.

Three thousand physicians and allied health personnel are expected to attend the assembly, which will feature five days of workshops, symposia, fireside conferences, and the presentation of 90 scientific papers. Also highlighting the assembly are luncheon panels, tutorial sessions, sunrise sessions, evening seminars, and a motion picture clinic.

Plans for opening day of the Scientific Assembly include clinic visits to 11 hospitals and teaching centers in Toronto. In addition, a one-day seminar for nurses and senior respiratory therapists on modern methods of managing patients with cardiorespiratory disease has been planned.

Registration fee information and advance registration forms are available from the American College of Chest Physicians, 112 E. Chestnut St., Chicago, Ill. 60611.

## HOUSE OF DELEGATES / Continued

ing battle on the "Chiropractic issue" during the 1973 Regular Session of the Mississippi Legislature. Considering everything, and remembering the old adage that "... legislation is like sausage, if you plan to enjoy it you don't want to watch it being made," your Board and council feel that we came out reasonably well. We would like to note the efforts of many members in this regard and we especially commend our president, Dr. Jenkins, for the time he spent in Jackson and on the telephone in Laurel in behalf of the association's legislative program.

*Future Legislative Activities and Recommendations.* Bills to reorganize the State Board of Health with a majority of lay members composing the Board, to require a certificate of need for all hospital construction, and to allow counties to issue full faith and credit bonds for construction of medical arts buildings in conjunction with hospitals were introduced during the 1973 Regular Session and successfully opposed by the association. All will more than likely be back on the 1974 Legislative Agenda. Your Board and Council on Legislation have considered ways for the association to strengthen its legislative program.

Over the next few months preceding the 1974 Regular Session of the Mississippi Legislature we propose to organize county by county legislative contact committees which will coordinate the association's legislative program with their respective members of the legislature. We also propose to begin formulation of a legislative "health voting index" to illustrate your representatives' and senators' votes on key health issues during the 1972-76 Mississippi Legislature.

Finally, and not in regard to a recommendation, your Board of Trustees and Council on Legislation wish to stress that with the shift on the Federal level to revenue sharing and the decentralization of government programs, state legislatures become more and more a focal point of activity for health legislation and appropriations. We must constantly strive to improve our state legislative program.

### REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered Supplemental Report A of the Board of Trustees, 1973 MSMA Legislative Program. The report recommends organization of county legislative contact committees and the formation of a "health voting

index" for each member of the Legislature. We concur with these recommendations and commend our president, Council on Legislation, and the Board of Trustees for their efforts during the 1973 Mississippi Legislature in our behalf.

The report of the reference committee was adopted.

### SUPPLEMENTAL REPORT B OF THE BOARD OF TRUSTEES

*Professional Standards Review Organizations—Background.* With the passage of H.R.I, the Social Security Amendments of 1972, and its signing into law by the President as Public Law 92-603, the private practice of medicine faces one of its most crucial challenges and opportunities in recent times. I refer specifically to the now famous or as some may prefer infamous provision in that law titled "Professional Standards Review Organizations" (PSRO).

Much has been said and written by way of explanation about PSRO in the past few months. Many hopes and fears have been expressed about it by physicians, Medicare and Medicaid intermediaries, insurance companies, politicians, and others. I do not propose to state here today the many words of hope or fear so well stated by others. I do want to say to you, however, that your Board of Trustees has reviewed and considered the PSRO Law, that we desire to bring certain pertinent information to you about it, and finally we have recommendations to make for your consideration as the elected representatives of the members of our association.

*PSRO—Plan and Format.* Under requirements of the PSRO Law, the Secretary of H.E.W. is to designate PSRO areas throughout the country by January 1, 1974. These areas will generally include a minimum of 300 physicians. Maximum size of a PSRO area has yet to be defined, although there is indication that some entire states may be one PSRO area. A state having more than two PSRO areas will have a statewide PSRO Council to serve as a coordinating mechanism for PSRO activities in the state.

After designation of PSRO areas the Secretary of H.E.W. is to seek applicants to serve as Professional Standards Review Organizations. These organizations will be responsible for the review of all health care services for which payment may be made under the Medicare and Medicaid Programs. In this regard the PSRO will be concerned with: (1) necessity of services; (2) quality of services; and (3) appropriateness of institutional services. The PSRO will be concerned first with review of institutional services.



The Secretary of H.E.W. must initially seek PSRO sponsors from among medical organizations. A medical association can not be a PSRO but it can be a PSRO sponsor. Failing such sponsors the Secretary of H.E.W. is directed to seek alternative PSRO sponsors from among state and local health departments, medical schools and third party payors.

Finally with respect to the PSRO plan and format, it should be noted that the PSRO Director on the national level reports directly to the Assistant Secretary of H.E.W. for Health and Scientific Affairs, Dr. Charles C. Edwards. The PSRO Director is Dr. William I. Bauer, a practicing physician from Greeley, Colorado and former president of the Colorado Medical Care Foundation. The Director is advised by a National Professional Standards Review Council composed of a majority of physicians selected from national organizations representing practicing physicians.

*PSRO in Mississippi—An Overview and Recommendations.* In 1971 this House of Delegates authorized the formation of the Mississippi Foundation for Medical Care, Inc. As noted then such voluntary foundations have four principal functions: (1) To conduct peer review; (2) to provide for the medical profession assuming direct responsibility for and leadership in care delivery; (3) to provide the most knowledgeable and capable source for claims processing and payment information; and (4) to support utilization review.

In 1970 and 1971 this House of Delegates recognized “. . . the importance and timeliness of a valid peer review system . . .” and directed that such a system “. . . be instituted at the earliest possible time . . . and incorporated in the work of the Mississippi Foundation for Medical Care as the foundation is developed. . . .” Then in June of 1971 the association was awarded a grant by the National Center for Health Services Research and Development to develop a “. . . physician-sponsored method of evaluating quality of medical care.”

PSRO—that is a voluntary organization of physicians to review the quality, appropriateness, and necessity of medical services does not conflict with these several actions of the House of Delegates. As a matter of fact we are in a better and more logical position to talk about what PSRO will be than PSRO is at this early stage in its development.

This is not to say that we don't have a lot of work to do on development of our Foundation and peer review mechanism. As reported in the

*Handbook of the House of Delegates*, the Foundation has just begun study and development of professional fee schedules. Our initial efforts have been directed toward reaching that membership total necessary for meaningful direction. Additionally, our Peer Review/EMCRO activities are now at that point where we can identify and support operational mechanisms on the local level. These activities should now evolve to the local hospital staff, with local regional review and a state appeal and support mechanism.

After review of the PSRO Legislation and consideration of the content and context of the association's heretofore activities which precede such legislation, your Board of Trustees respectfully recommends and encourages this House of Delegates to direct the Mississippi Foundation for Medical Care, Inc., to proceed to organize PSROs in Mississippi as required by Public Law 92-603 and within the context of the principles of the MFMC as voluntarily endorsed by its members and this House of Delegates.

We further recommend that the peer review process as authorized by this House of Delegates, and implemented with respect to third party payors and physicians accepting contractual assignments from such third parties, be now incorporated into the work of the MFMC to be voluntarily assumed by its members.

#### REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered Supplemental Report B of the Board of Trustees, Professional Standards Review Organizations. This detailed and thoughtful report on a very complex subject deserves our most careful consideration. The report recommends that the House of Delegates direct the Mississippi Foundation for Medical Care to proceed to organize PSROs in Mississippi as required by Public Law 92-603 and within the context of the principles of the MFMC as voluntarily endorsed by its membership and this House of Delegates. It further recommends that the peer review process as authorized by this House of Delegates and implemented with respect to third party payors and physicians accepting contractual assignments from such third parties, be now incorporated into the work of the MFMC to be voluntarily assumed by its members. Your reference committee concurs with these recommendations.

A minority report was presented by Dr. Jack A. Stokes—seconded by Dr. Max Pharr. The mo-

## HOUSE OF DELEGATES / Continued

tion was made by Dr. Lawrence W. Long, seconded by Dr. John Caden, and passed, that the minority report be adopted as part of the report.

The report of the reference committee was adopted as amended.

### MINORITY REPORT ON ITEM 8 OF THE REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

*Dr. Jack A. Stokes:* This is a minority report from your Reference Committee on Reports of Officers and Board of Trustees. Realizing that PSRO is now "the law of the land" and being knowledgeable of the fact that physicians have been promised *first* opportunity for setting up such an organization, we concur with an obvious, immediate necessity for the Mississippi State Medical Association to become instrumental in setting up this organization. We do, however, disagree with the principles of such an organization and for the necessity for physicians to have to deal with third party payors for their fee for services. It was brought out in your reference committee's hearing that this House of Delegates a few years ago went on record as recommending that "(1) That insofar as possible, they, the physicians, deal directly with the patient, and (2) That the patient receive his Medicare benefits from the carrier by presentation of a receipted bill." It was further defined that that official stand has to this date not been changed but is being challenged by the proposed recommendation. It is further believed that the principles set out in PSRO are not consistent with that involved in the private practice of medicine and that this will inevitably widen the gap in the physician/patient relationships.

### SUPPLEMENTAL REPORT C OF THE BOARD OF TRUSTEES

*Scheduling of MSMA Annual Sessions.* The Constitution of the association provides for the annual session, and under the By-Laws, it must be conducted prior to the annual convention of AMA. Section 2, Article V, of the Constitution states that "the time and place for holding the annual session shall be fixed by the House of Delegates, but in emergencies, the Board of Trustees shall have the power to fix or change either the time or the place or both. . . ." Because of scheduling difficulties on a year-to-year basis, the House of Delegates approved a four-year advance schedule beginning in 1967.

A resolution was passed by the House of Delegates in 1970 directing that the annual sessions be scheduled to avoid conflict with Mother's Day

and with municipal elections. The former occurs on the second Sunday in May; primaries for the latter occur on the second Tuesday in May every four years.

*Recommended Dates and Sites for the Annual Sessions.* At the 99th Annual Session in 1967, the House agreed that the annual session thereafter would be conducted on the Gulf Coast "until such time as more adequate and suitable convention facilities are made available at Jackson."

To maintain our four-year advance schedule, the Board of Trustees recommends that the following convention schedule be adopted and that the convention continue to be held in Biloxi.

<i>Annual Session</i>	<i>Dates</i>
106th	May 6-9, 1974
107th	May 5-8, 1975
108th	May 3-6, 1976
109th	May 2-5, 1977

### REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Your reference committee considered Supplemental Report C of the Board of Trustees dealing with scheduling of annual sessions of the association. The following schedule was proposed in this regard:

<i>Annual Session</i>	<i>Dates</i>
106th	May 6-9, 1974
107th	May 5-8, 1975
108th	May 3-6, 1976
109th	May 2-5, 1977

We concur with the schedule of annual sessions proposed by the Board. We note that at the present time there are only two convention facilities in the state that can handle annual meetings of this association. Both are located on the Gulf Coast. We recommend that the exact site of the association's annual sessions be left to selection by the Council on Scientific Assembly.

The report of the reference committee was adopted.

### REPORT OF THE SECRETARY-TREASURER

*Dr. Raymond S. Martin, Jr.: Duties and Responsibilities.* As an elected general officer of the association, your Secretary-Treasurer is charged with such duties as ordinarily devolve upon the secretary of a corporation by law, custom, and usage. Additionally, he is the constitutional designee to serve as chairman of the Council on Scientific Assembly and member *ex officio* of all councils and committees.

*Membership.* Total membership as of December 31, 1972, was as follows:



HOUSE OF DELEGATES / Continued

- 1,302 paid Active members
- 56 Emeritus members
- 54 members exempt from dues other than Emeritus

This is a total of 1,412 MSMA for 1972. As of April 15, 1973, our current year's membership was:

- 1,283 paid Active members
- 55 Emeritus members
- 41 members exempt from dues other than Emeritus

This is a total of 1,379 for 1973. Additional payments of dues have been made since preparation of these data.

*Fiscal Reporting.* In accordance with usual practice, your Secretary-Treasurer submits a condensed statement of your association's financial condition as reported by the Board of Trustees' independent certified public accountant. The Council on Budget and Finance prepared the budget for 1973 which was approved by the Board of Trustees, and a copy is attached to this report. This is exclusive of funds which will be expended by the association in payment of claims under the Civilian Health and Medical Program of the Uniformed Services. Such expenditures are reimbursed to the association by the Department of Defense.

*Constitutional Duties.* Your Secretary-Treasurer,

as an *ex officio* member of councils and committees, meets with various official bodies of the association and sits with the Board of Trustees as a general officer. Activities related to service as chairman of the Council on Scientific Assembly are reported separately.

MISSISSIPPI STATE MEDICAL ASSOCIATION  
CONDENSED STATEMENT OF  
FINANCIAL CONDITION  
DECEMBER 31, 1972  
ASSETS

<i>Current Assets</i>		
General Fund		
Cash on Deposit	\$168,693.87	
Accounts Receivable—		
JOURNAL	3,980.01	
Accounts Receivable—		
CHAMPUS	7,265.63	
Other Current		
Receivables	3,532.96	
Prepaid Expenses	255.39	
Total Current Assets		\$183,727.86
<i>Fixed Assets</i>		
Building, Office Furniture & Equipment, Less Depreciation		184,344.25
Land (at cost)	14,242.38	
Total Fixed Assets		198,586.63
<i>Deferred Expenses</i>		
Deferred CHAMPUS Expenses		2,254.26
Deferred Pension Plan Expense	5,984.43	
Total Deferred Expenses		8,238.69
<i>Other Assets</i>		
Refundable Deposits	202.98	
Due from Mississippi Foundation for Medical Care	709.06	912.04
Total Assets		\$391,465.22

MEMBERSHIP SUMMARY—AS OF APRIL 15, 1973

<i>Society</i> (1)	<i>Paid</i> <i>MSMA</i> (2)	<i>Emer.</i> <i>MSMA</i> (3)	<i>Exmp.</i> <i>MSMA</i> (4)	<i>Total</i> <i>MSMA</i> (5)	<i>Paid</i> <i>AMA</i> (6)	<i>Exmp.</i> <i>AMA</i> (7)	<i>Total</i> <i>AMA</i> (8)	<i>1972</i> <i>Total</i> (9)	<i>PPSA</i> (10)
Adams County	48	0	2	50	42	1	43	53	51
Amite-Wilkinson	7	0	0	7	7	0	7	8	8
Central	369	20	14	403	301	30	331	422	540
Claiborne County	2	0	1	3	2	1	3	3	3
C'Dale & Six	35	2	3	40	29	3	32	42	44
Coast Counties	101	8	1	110	88	9	97	111	172
Delta	103	1	6	110	96	7	103	113	132
De Soto County	4	0	0	4	4	0	4	4	6
East Miss.	92	3	1	96	86	3	89	93	108
North Miss.	47	4	0	51	40	4	44	47	65
North Central	35	0	1	36	34	0	34	36	44
Northeast	112	8	3	123	105	11	116	119	148
Pearl River	13	0	0	13	12	0	12	14	15
Prairie	43	1	2	46	37	3	40	46	58
Singing River	42	0	1	43	29	1	30	45	58
South Miss.	142	4	3	149	126	7	134	155	187
South Central	48	3	0	51	44	3	47	55	74
West	40	1	3	44	38	4	42	49	55
Totals	1,283	55	41	1,379	1,120	87	1,208	1,415	1,768

<sup>1</sup>Physician population in society area as of November 1972; includes both sexes and federal medical officers of VA and USPHS, but does not include non-members in residency or intern training programs.

HOUSE OF DELEGATES / Continued

LIABILITIES AND NET WORTH

<i>Current Liabilities</i>	
Accrued Expenses	\$ 4,072.09
Accounts Payable:	
Local Society Dues	4,135.00
Auxiliary Dues	4,216.00
Accounts Payable—AMA	
Dues and ERF	82,052.20
Accounts Payable—Dues	
AMPAC and MPAC	8,860.00
Accounts Payable:	
EMCRO	3,705.36
CHAMPUS	4,828.87
Mortgage Payable	4,450.00
Accrued Taxes	3,345.00
Due United Givers Fund	121.60
Total Current Liabilities	\$119,786.12
<i>Long Term Liabilities</i>	
Mortgage Payable—	
Deposit Guaranty	
National Bank	66,750.00
<i>Deferred Income</i>	87,058.79
<i>Net Worth</i>	
Unappropriated Net Worth,	
December 31, 1971	110,643.99
Net Income for Year Ended	
December 31, 1972	7,226.32
Net Worth, December 31,	
1972	117,870.31
Total Liabilities and	
Net Worth	\$391,465.22

MISSISSIPPI STATE MEDICAL ASSOCIATION  
1973 BUDGET

<i>Projected Income</i>	
<i>Dues Sources</i>	
1,340 MSMA @ \$100	\$ 134,000.00
1,175 AMA @ \$110	129,250.00
AMA Commissions @ 1% of Dues	1,293.00
Associate Member Service:	
Fees @ \$15 per Assoc. Member	75.00
Directory and Supplement	4,000.00
<i>Journal</i>	
Advertising	\$27,000.00
Other (Rebate, Paid Subs.)	1,600.00
Reprints	1,000.00
	29,600.00
<i>105th Annual Session</i>	
Exhibit Sales	8,000.00
Scientific Grants	550.00
Social Occasion	1,000.00
	9,550.00
<i>Other Income</i>	
Interest Earned	2,500.00
Sundry Sales	1,000.00
Data Processing	1,000.00
CHAMPUS Administration	77,500.00
Medex Data	5,000.00
EMCRO Grant	197,900.00
	284,900.00
Total	592,668.00
Less AMA Transmittals	-129,250.00
Less EMCRO Grant	-197,900.00
Less CHAMPUS	
Administration	- 77,500.00
Net Projected Income	\$ 188,018.00

<i>Projected Expenses</i>	
105th Annual Session	\$ 7,950.00
Board of Trustees	3,600.00
Councils and Committees	2,000.00
Committees—CHAMPUS	350.00
Building Maintenance	3,100.00
Contract Labor	300.00
Dues and Subscriptions	550.00
Equipment Rentals	1,800.00
Office Equipment Maintenance	800.00
Office Equipment Maintenance—	
CHAMPUS	250.00
Office Equipment Maintenance—EMCRO	150.00
Ground Maintenance	700.00
Group Insurance	2,000.00
Group Insurance—CHAMPUS	1,150.00
Group Insurance—EMCRO	1,400.00
Other Insurance	1,000.00
Interest	4,300.00
Other Office Expenses	350.00
Postage	7,800.00
Postage—CHAMPUS	5,100.00
Postage—EMCRO	2,650.00
Professional Services	3,500.00
Professional Services—CHAMPUS	900.00
Consultant Services—EMCRO	27,640.00
Pension Plan	1,250.00
Pension Plan—CHAMPUS	215.00
Data Processing Services	9,600.00
Data Processing Services—CHAMPUS	6,000.00
Data Processing Services—EMCRO	79,200.00
Salaries	71,359.00
Salaries—CHAMPUS	37,355.00
Salaries—EMCRO	62,333.00
Printing and Supplies	12,500.00
Printing and Supplies—CHAMPUS	6,000.00
Printing and Supplies—EMCRO	7,208.00
Property Taxes	6,700.00
Payroll Taxes	3,800.00
Payroll Taxes—CHAMPUS	2,500.00
Payroll Taxes—EMCRO	2,900.00
Telephone and Telegraph	6,000.00
Telephone and Telegraph—CHAMPUS	2,700.00
Telephone and Telegraph—EMCRO	1,590.00
Travel	7,500.00
Travel—CHAMPUS	1,000.00
Travel—EMCRO	4,240.00
Utilities	5,600.00
Journal Production	25,200.00
Journal Other	1,900.00
Journal Reprints	1,000.00
EMCU	2,000.00
Medex Data	1,000.00
Total	447,990.00
Less OCHAMPUS Expenses	- 63,520.00
Less EMCRO Grant	-189,311.00
Net Projected Expenses	\$ 195,159.00

REPORT OF THE REFERENCE COMMITTEE  
ON REPORTS OF OFFICERS AND  
BOARD OF TRUSTEES

Your reference committee thanks and commends the Secretary-Treasurer, Dr. Raymond F. Martin, Jr., for his report. During consideration of the report it was pointed out to the reference committee that the budget reflected a need for either cutting back the association's present activities, increasing dues, or increasing membership. Your reference committee recommends that the latter, that is, increasing our membership, be



vigorously pursued by all members of the association.

The report of the reference committee was adopted.

#### REPORT OF THE COUNCIL ON BUDGET AND FINANCE

We have considered the fiscal portion of the report of the Secretary-Treasurer, and we have examined the operation of the Association with respect to all fiscal activities, including the report of our auditor. The report is satisfactory to your Council. Prior to this annual session, we have met for this purpose and conferred with the Board of Trustees. We have determined that the accounting system is working properly.

We have also considered the 1973 budget for operation of your Association, and we have conferred with the Board of Trustees who have approved the budget for 1973. Each item in the budget has been carefully evaluated and we recommend a total budget of \$447,990.00 for general operation of all activities in the departments of the Association. We recommend adoption of the budget for the continued operation of your Association. The insurance owned by the Association on its properties and against certain liabilities has been examined and found to be adequate. Safeguards for disbursement procedures, the handling of incoming funds and the safeguarding of records have been provided as recommended by our auditor.

The Association increased its working capital by \$10,045.72 in 1972 to \$63,941.74 and increased its current ratio to 1.53 to 1 at December 31, which is normally considered good. However, without prepaid income (1973 dues) our working capital at December 31, 1972, would have been a deficit of \$23,117.05, and a current ratio of .81 to 1. The Council is very concerned over this deficiency in working capital and it has referred this problem to the Committee on Long Range Planning for study and recommendation to the Board of Trustees. The Association's dependency on government programs has also been brought to the Council's attention. In 1972 the Association would have had a minimum negative cash flow of \$7,315.74 based on last year's operation without the cost absorption by the government programs. This too, has been referred to the Committee on Long Range Planning for their study and recommendations to the Board of Trustees.

The report of the Council on Budget and Finance was adopted.

#### REPORT OF THE EXECUTIVE SECRETARY

*Mr. Charles L. Mathews, Executive Secretary:*

Your office of Executive Secretary, under the By-Laws, reports to the Board of Trustees. The present report omits this detailed reporting and is limited to an overview of your administrative staff and on-going association activities.

*Staff.* There are at present 22 employees at your headquarters building. Six of these staff members have duties with the Experimental Medical Care Review Organization (EMCRO). Eight have duties with the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and eight have duties with association programs such as membership, the JOURNAL, internal management, etc. In the latter group, three employees have 50 per cent time responsibilities with the CHAMPUS. We have two key staff positions vacant, one in computer systems support and the other in general administration which were enumerated to you last year. I am happy to acknowledge the Board's approval to fill these two key positions, the former position being filled based upon third year funding of the EMCRO.

*Association Programs.* With the approval of the Board, we have acted to increase channels of communication between members and the association's programs. The Board has directed publication of a summary in your JOURNAL of its meetings and the meetings of the Mississippi Foundation for Medical Care, Inc. We will expand this effort during the upcoming year to include other council and committee meetings. The "Blue Sheet" is now published monthly between Legislative Sessions, carrying news on national legislation and state activities of medical interest. We will begin annual publication this summer of a new membership brochure titled "MSMA—Services and Activities." We are testing the benefits of a watts-line on a one way basis at the present time, using it hopefully to give better service and quicker response to your requests. We have attempted to have a staff member present at any component society meeting this past year where anyone gave any type of slight indication that they would like to see us. I believe we batted about 90 per cent on this.

*Summary.* In closing let me say on behalf of your headquarters staff that we have a firm desire to serve well and to improve. Just as a personal word on behalf of myself, and Phoebe, let me say it's nice to be back with the medical profession. Quite frankly, Phoebe and I don't know whether the brief absence amounted to a circle or a wild

## HOUSE OF DELEGATES / Continued

tangent but at any rate I do hope that I return with more ability to serve you well and it is nice to be back home.

### REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered the report of the Executive Secretary, Mr. Charles L. Mathews, and commend him and our staff for their work. The committee has decided that the Executive Secretary's return completes a circle and hopefully he has not been off on any wild tangents.

The report of the reference committee was adopted.

### REPORT OF THE COMMITTEE ON AMA-ERF

Dr. Charles R. Jenkins, MSMA president (in absence of committee chairman, Dr. Raymond F. Grenfell):

*Organization and Duties.* Your Committee on AMA-ERF is composed of one member from each component medical society appointed annually by the president of our association. The committee works in conjunction with the American Medical Association-Education and Research Foundation and solicits voluntary contributions from Mississippi physicians for medical education and research. The committee also closely coordinates its activities with the fund solicitation campaigns of the University of Mississippi Medical Alumni Association. All contributions are tax deductible and every dollar received is put to work in education in a medical school of the donor's choice or in medical research. The AMA and state medical associations pay the modest costs of conducting the program.

*1972 Contributions.* Your committee is happy to report that the AMA-ERF contribution to our University of Mississippi School of Medicine for 1972 totals \$16,540.56. Of this total \$14,693.72 represents contributions from physicians and the Woman's Auxiliary designated for the University; the other \$1,846.84 represents the University's share of undesignated contributions to AMA-ERF. Your committee would like to note that this 1972 AMA-ERF contribution represents the largest in the history of the program in Mississippi. Also, we note with a great degree of pride that out of some ninety-five medical schools our University of Mississippi School of Medicine is among the "Top Ten" in contributions from its alumni and friends during 1972.

*Presentation of UMC Contribution.* At this

time I ask the president of the University of Mississippi Medical Alumni, Dr. Bobby F. King, and the Dean of our University of Mississippi School of Medicine, Dr. Blount, to come forward for presentation of the 1972 AMA-ERF contribution, a check in the amount of \$16,540.56.

### REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Your committee considered the report of the Committee on AMA-ERF as presented by its Chairman, Dr. Raymond F. Grenfell. We commend the committee, the Woman's Auxiliary, and the Ole Miss Medical Alumni Association for their efforts in soliciting the largest AMA-ERF contribution in the history of the program in our state.

The report of the reference committee was adopted.

### AUXILIARY OFFICERS

The speaker presented Mesdames Clarence H. Webb, Jr., of Jackson, 1972-73 president of the Woman's Auxiliary to the Mississippi State Medical Association, and W. H. Preston, Jr., of Booneville, 1973-74 president, who addressed the House of Delegates. The announcement was made that Mrs. John M. McRae of Laurel is the new president-elect of the woman's group.

### 1973 MSMA-ROBINS AWARD

President Jenkins presented the 1973 Mississippi State Medical Association-Robins Award to Dr. William A. Long, Jr., of Jackson for outstanding community service by a physician. Dr. Long, a specialist in adolescent medicine, was cited for his work with the Youth Crisis Center and in the area of drug abuse education. Mr. Willard Duvall from the A. H. Robins Company assisted Dr. Jenkins in the presentation of the award, an engraved plaque.

### SCIENTIFIC EXHIBIT AWARDS

Dr. Raymond S. Martin, Jr., of Jackson, chairman of the Council on Scientific Assembly, presented the Aesculapius Award, an engraved wooden plaque, to Drs. Richard C. Miller and Patricia Moynihan of the University Medical Center for the best scientific exhibit by a member or members of the association, "Intravenous Nutrition."

The second place award in this category, also an engraved plaque, was presented to Dr. Robert L. Abney, III, of Jackson for his exhibit, "Care of Infants with Congenital Heart Disease."

The Mississippi State Medical Association Scientific Achievement Award, a bronze medallion,



given for the best scientific exhibit by nonmember, out-of-state guests, was awarded to Drs. Hector S. Howard, H. Edward Garrett, J. T. Davis, Jr., and Charles V. Stewart of Memphis for their exhibit, "Surgery for the Prevention and Treatment of Stroke."

Dr. Martin also gave honorable mentions to the following exhibits: "Surgery for the Heart Attack," by Drs. Akio Suzuki and James D. Hardy of the University Medical Center; "Aorto-Coronary Bypass Surgery for the Relief of Angina Pectoris," by Dr. Thomas L. Kilgore of Jackson; "Charnley Total Hip Replacement," by Drs. John G. Caden and Clyde X. Copeland, Jr., of Jackson; "Serous Otitis Media," by the Ear, Nose and Throat Surgical Group, P.A. of Jackson; and "University of Alabama Maxillofacial Prosthetics Treatment and Training Center," by Dr. Iradj Sooudi of Birmingham.

Dr. Martin announced that certificates of merit would be presented to all scientific exhibitors and he also expressed appreciation for the 37 technical exhibits at the 105th Annual Session and five scientific grants. He noted that there had been an increase in attendance and in scientific and technical exhibits at the 105th Annual Session.

#### SPECIAL ADDRESS

Dr. J. Dan Mitchell of Jackson asked and received the unanimous consent of the House of Delegates for Mr. Fred Andre, field representative of the AMA, to address the House on AMPAC activities.

#### SPECIAL MEETING OF THE MISSISSIPPI FOUNDATION FOR MEDICAL CARE

The chair declared adjournment of the House of Delegates for the second annual meeting of the Mississippi Foundation for Medical Care. Dr. J. T. Davis of Corinth, MFMC president, presented the Constitution and By-Laws to the foundation members for approval. On motion by Dr. Guy T. Vise of Meridian, seconded by Dr. Walter Rose of Indianola, and passed by vote of the House, the Constitution and Bylaws were adopted. Dr. Gerald P. Gable of Hattiesburg and Dr. Davis presented reports on the status of MFMC activities. Said reports were previously published in the April and May issues of the JOURNAL MSMA. On motion by Dr. John B. Howell of Canton, seconded by Dr. Visc, the meeting of the foundation was adjourned.

#### RESOLUTION NO. 1, IN MEMORIAM

*Dr. Raymond S. Martin, Jr.:*

WHEREAS, There are absent from among our numbers 23 members who have been called by

Divine Providence since the 104th Annual Session; and

WHEREAS, Although we are grieved by the passing of these beloved colleagues and friends, we are inspired by their lives of service and professional attainment; and

WHEREAS, This expression of our grief, deep affection, and respect should be recorded permanently among official records of the Mississippi State Medical Association, now therefore, be it

*Resolved*, That this House of Delegates does mourn the passing of the following esteemed colleagues:

William L. Anderson, Southaven, July 6, 1972

Terry Lee Bennett, Meridian, May 15, 1972

Caesar B. Christian, Jackson, June 9, 1972

Filo B. Coats, Hardy, September 19, 1972

Edward A. Copeland, Jackson, December 15, 1972

William H. Dawkins, Whitfield, October 19, 1972

James B. Dillard, Vicksburg, May 5, 1972

Emma Von Gay, Biloxi, August 28, 1972

William A. D. James, Midnight, November 14, 1972

John S. Laird, Union, February 26, 1973

James L. Lowry, Jr., Mound Bayou, August 1, 1972

Thomas E. Magee, Gulfport, July 30, 1972

Edwin M. Meek, Greenwood, January 25, 1973

Mohamed Mobarak, Jackson, November 1, 1972

Chester C. Moe, Richton, April 6, 1973

Stanley L. Pharr, Booneville, January 10, 1973

D. A. Ratliff, Columbia, February 27, 1973

William W. Reynolds, Jr., Biloxi, September 6, 1972

E. W. Ryan, Charleston, October 1, 1972

Robert P. Sayle, Dundec, July 12, 1972

Leo O. Stewart, Pascagoula, July 25, 1972

Albert G. Tillman, Gulfport, July 26, 1972

Sharkey Wolfe, Greenville, May 17, 1972

#### ACTION OF THE HOUSE OF DELEGATES

Without objection, Resolution No. 1 was acted upon without referral and adopted by the House of Delegates with all present standing in silent tribute.

#### RESOLUTION NO. 2, COMPOSITION OF THE MSMA BOARD OF TRUSTEES

*Dr. Tom H. Mitchell:* WHEREAS, The Mississippi State Medical Association (hereinafter referred to as MSMA) advances the medical profession and sets high ethical and moral standards for physicians; and

WHEREAS, The MSMA represents organized medicine in Mississippi and its actions vitally affect every physician, especially in the areas of fed-

erally enforced "Peer Reviews"; and

WHEREAS, Section IX of the MSMA Constitution created a Board of Trustees; and

WHEREAS, "The Board of Trustees shall be the Executive and Governing Board of the Association . . ." (MSMA Constitution, Section IX); and

WHEREAS, Each of the nine men on the Board of Trustees has equal voting rights, equal executive and other great powers over the MSMA; and

WHEREAS, That Trustee of District 4 represents only 32 MSMA members, whereas that Trustee of District 5 represents 446 MSMA members; and

WHEREAS, Similar, but less pronounced, examples of unequal membership representation occurs in other Trustee Districts, now therefore let it be

*Resolved*, That such obvious inequalities create obstacles to the proper function and member rights of a democratic, scientific organization, such as the MSMA; and be it

*Resolved Further*, That Section VIII, article 8 of the MSMA Constitution be amended to provide that all Trustee Districts shall include substantially equal numbers of MSMA members; and be it

*Resolved Further*, That the West Mississippi Medical Society direct its MSMA House Delegate to introduce this resolution, after first pre-filing it with the Executive Director of the MSMA, at the upcoming MSMA House of Delegates' meeting to be held in Biloxi, Mississippi, April 30-May 3, 1973.

#### REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

Your reference committee considered Resolution No. 2 introduced by Dr. Tom H. Mitchell, Delegate from West Mississippi Medical Society, in behalf of the West Mississippi Medical Society. This resolution states:

"*Resolved*, That such obvious inequalities create obstacles to the proper function and member rights of a democratic, scientific organization, such as the MSMA, and be it

"*Resolved Further*, That Section VIII, article 8 of the MSMA Constitution be amended to provide that all Trustee Districts shall include substantially equal numbers of MSMA members; and be it

"*Resolved Further*, That the West Mississippi Medical Society direct its MSMA House Delegate to introduce this resolution, after first pre-filing it with the Executive Director of the

MSMA, at the upcoming MSMA House of Delegates meeting to be held in Biloxi, Mississippi, April 30-May 3, 1973."

Your reference committee considered this resolution along with Resolution No. 11 and Recommendation No. 4 in the President's address. The overwhelming majority of persons appearing before your reference committee were in favor of re-aligning our present trustee districts so that they contain substantially equal numbers of MSMA members. Your reference committee believes that this is a project that will require careful study and evaluation. We, therefore, recommend that an *ad hoc* committee of the House of Delegates be formed to study realignment of the nine association districts to more equitably divide the districts as to number of physician members. Said committee is to report back with concrete suggestions to the 1974 House of Delegates.

The motion was made by Dr. Ellis Moffitt and seconded by Dr. S. H. McDonnieal, and passed that the last sentence be changed to read, "We, further recommend that said *ad hoc* committee return with a definitive plan for implementing the re-districting of the trustee districts at the 106th Annual Session of the association."

The report of the reference committee was adopted as amended.

#### RESOLUTION NO. 3. NURSING PRACTICE ACT

*Dr. Tom H. Mitchell*: WHEREAS, Section 8806-10 (a) (2) Mississippi Code of 1942 states that qualifications of an applicant for licensure as a registered nurse must be "a citizen of the United States or has legally declared the intention of becoming a citizen or has been legally resident in the United States for at least one (1) year," and

WHEREAS, There are constructive and meritorious efforts to recruit nurses who are citizens of other countries in an effort to relieve the shortage of nursing personnel in our State, and

WHEREAS, There is often an inability for foreign nurses to adequately understand the English language and medical terminology sufficiently at the time of entering the United States, and

WHEREAS, Studies have shown that the foreign nurse does better on state nursing board examinations after a year of adjustment, orientation, study and clinical experience in the United States, and

WHEREAS, There are cogent legal and ethical reasons for maintaining a standard of nursing care, now therefore be it

*Resolved*, That the Mississippi State Medical Association does indicate its appreciation and



support for the Mississippi Board of Nursing in its application of Section 8806-10 (a) (2), Mississippi Code of 1942, dealing with citizenship and residence of applicants for licensure.

#### REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Your reference committee considered Resolution No. 3 introduced by Dr. Tom H. Mitchell, Delegate from West Mississippi Medical Society. The resolution states:

*"Resolved, That the Mississippi State Medical Association does indicate its appreciation and support for the Mississippi Board of Nursing in its application of Section 8806-10 (a) (2), Mississippi Code of 1942, dealing with citizenship and residence of applicants for licensure (as registered nurses)."*

Your reference committee concurs with the intent of this resolution but recommends that it be amended as follows to indicate our support for the intent of this law only since we have no day to day knowledge of how the law is being applied:

*Resolved, That the Mississippi State Medical Association does indicate its appreciation and support of Section 8806-10 (a) (2), Mississippi Code of 1942, dealing with citizenship and residence of applicants for licensure (as registered nurses).*

The report of the reference committee was adopted.

#### RESOLUTION NO. 4, DISCRIMINATION UNDER MEDICARE

*Dr. Donald R. Ellis:* WHEREAS, From its inception the Medicare program committed itself to the physicians of this country to pay usual and customary fees for medical services to eligible individuals; and

WHEREAS, The overwhelming majority of physicians in Mississippi accepted this commitment in good faith and provided the professional services promised to these people; and

WHEREAS, The Travelers Insurance Companies of America as intermediary agent for part B Medicare in Mississippi, has arbitrarily and with utter disregard for the physician concerned, established two areas for determining prevailing fees; and

WHEREAS, The significantly different prevailing fees established by Travelers deny the elderly citizen of most of Mississippi the benefits provided for them by Congress; and

WHEREAS, This arbitrary act by Travelers will

make it even more difficult for the rural area of the state to obtain the physicians they so desperately need;

WHEREAS, Faith, trust and respect for his physician is essential to the most effective medical care; and

WHEREAS, The arbitrarily altering and innumerable errors on the part of Travelers, with insulting notifications to the patient that his physician has overcharged him unjustly destroys the patient's faith and trust in his physician; and

WHEREAS, In the seven years of Medicare only totally ineffective efforts have been made by our society to correct this discriminating action against so many of its dues paying members; now

*Therefore, Be It Resolved, That the Mississippi State Medical Association immediately take legal action as a class action for the members of the association and the elderly members of the state against Travelers Insurance Company of America to stop this discrimination against and unnecessary interfering into the effectiveness of the medical care provided for the elderly citizens of this state by so many of the members of this society.*

#### REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered Resolution No. 4, Discrimination Under Medicare, introduced by Dr. Donald R. Ellis, Delegate from Clarksdale and Six Counties Medical Society, in behalf of the Clarksdale and Six Counties Medical Society. This resolution states:

*"Therefore, Be It Resolved, That the Mississippi State Medical Association immediately take legal action as a class action for the members of the association and the elderly members of the state against Travelers Insurance Company of America to stop this discrimination against and unnecessary interfering into the effectiveness of the medical care provided for the elderly citizens of this state by so many of the members of this society."*

Your reference committee is sympathetic to the many problems that physicians and their patients have had in dealing with the Medicare program. It was brought to your reference committee's attention that it would be legally impossible for your association, a non-profit, professional society of physicians, to seek the legal action requested by Resolution No. 4. We, therefore, recommend that the resolution be not adopted.

The report of the reference committee was adopted.

## HOUSE OF DELEGATES / Continued

### RESOLUTION NO. 5, INFORMATION TO MSMA MEMBERS

*Dr. Donald R. Ellis:* WHEREAS, The effectiveness of any group is determined by the extent to which its individual members participate in its activities; and

WHEREAS, An individual's participation in a group is determined by the extent to which he is informed of the purposes, goals, and activities of various parts of the group; and

WHEREAS, The weekly legislative report issued by the association has done an outstanding job in this area; and

WHEREAS, There is too often a feeling of isolation and non-involvement in association activities by many of its members; now

*Therefore, Be It Resolved,* That the existing legislative report be used as a method of informing all members of the association of the events occurring at all meetings during the year.

### REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered Resolution No. 5, Information to MSMA Members, introduced by Dr. Donald R. Ellis, Delegate from Clarksdale and Six Counties Medical Society, in behalf of the Clarksdale and Six Counties Medical Society. This resolution states:

*"Therefore, Be It Resolved,* That the existing legislative report be used as a method of informing all members of the association of the events occurring at all meetings during the year."

The Executive Secretary has informed the committee that the existing legislative report will be expanded to include the information requested in Resolution No. 5. With this in mind, we recommend adoption of Resolution No. 5.

The report of the reference committee was adopted.

### RESOLUTION NO. 6, PRINCIPLES FOR IMPLEMENTING H.R.I

*Dr. Donald R. Ellis:* WHEREAS, The primary interest and responsibility of the members of the Clarksdale and Six Counties Medical Society and the Mississippi State Medical Association is the best possible medical care for all the citizens of our area and the entire state of Mississippi; and

WHEREAS, We firmly believe that the overwhelming majority of the physicians of this state are honest, dedicated, and truly concerned about the patients in their care, and the exception to this is rare; and

WHEREAS, We feel that all attitudes and actions of our association should proceed from the basic truth that the above premises are true; and

WHEREAS, There appears to be a concentrated effort on the part of many groups to convince the public and even part of our profession that the average physician is incompetent and should have every act checked and double-checked by others (even by paramedical, secretarial, and nursing personnel), that he is concerned only about money, that organized medicine has deliberately sabotaged the health care of our citizens; and

WHEREAS, As basic criticisms from different groups are basically that either medical care is not available to people who need it or else that medical care costs are exorbitant and unjustified; and

WHEREAS, All recent emphasis on unnecessary checking and double-checking and funds spent on inadequate training of para-professionals tends either to decrease the quality of care given or decrease the efficiency and available time for adequately trained physicians to provide the type of care we wish our patients to have; and

WHEREAS, All the pressure on our profession is to give the lay individuals exact figures and criteria whereby they can control this profession with averages of mediocrity; and

WHEREAS, HR-I specifically states that professional services can be reviewed only by physicians and that the majority of the physicians in any area can eliminate any undesired reviewing organization or group; now

*Therefore, Be It Resolved,* That the Mississippi State Medical Association and its members as they implement HR-I have the following principles that must not be violated;

First: That whatever action that is taken or endorsed must improve the quality of medical care.

Second: That no irrelevant facts or figures be presented in such a way that they can be used to control the care of the patient so that he receives inadequate and inappropriate care;

Third: That all differences between physician and third-parties be resolved to the satisfaction of both before the patient is involved with real and implied criticism of the physician.

Fourth: That no action be taken or permitted that would further restrict the right of the physician or limit his practice to the detriment of the health or financial embarrassment of his patient.

Fifth: Be constantly aware that in guaranteeing a maximum permissible fee to third party carriers without insisting that it also be the minimal fee will result only in added profit for the carrier at the expense of the patient and the physician.



REPORT OF THE REFERENCE COMMITTEE  
ON REPORTS OF OFFICERS AND  
BOARD OF TRUSTEES

Your reference committee considered Resolution No. 6, Principles for Implementing HR-I, introduced by Dr. Donald R. Ellis, Delegate from Clarksdale and Six Counties Medical Society, in behalf of the Clarksdale and Six Counties Medical Society, which states:

*"Therefore, Be It Resolved,* That the Mississippi State Medical Association and its members as they implement HR-I have the following principles that must not be violated:

First: That whatever action that is taken or endorsed must improve the quality of medical care.

Second: That no irrelevant facts or figures be presented in such a way that they can be used to control the care of the patient so that he receives inadequate and inappropriate care.

Third: That all differences between physician and third-parties be resolved to the satisfaction of both before the patient is involved with real and implied criticism of the physician.

Fourth: That no action be taken or permitted that would further restrict the right of the physician or limit his practice to the detriment of the health or financial embarrassment of his patient.

Fifth: Be constantly aware that in guaranteeing a maximum permissible fee to third party carriers without insisting that it also be the minimal fee will result only in added profit for the carrier at the expense of the patient and the physician."

Your reference committee studied this resolution with great interest and we heard much discussion about it. Recognizing that HR-I (Public Law 92-603) is now the law of the land and that we are citizens of this land, we are reluctant to give any impression that we will not obey the law. We, therefore, recommend that Resolution No. 6 be adopted as guiding principles for the association to seek in the implementation of this unpalatable law.

The report of the reference committee was adopted.

RESOLUTION NO. 7, SUPPORT FOR  
MEDICREDIT

*Dr. C. D. Taylor, Jr.:* WHEREAS, There is increasing concern in the Congress and by the public about the enactment of any program for national health insurance; and

WHEREAS, Many proposals for national health insurance have been introduced in the Congress; and

WHEREAS, The medical profession is concerned for the continued development of quality medical

care and for the availability to all persons of insurance protection providing comprehensive health care benefits; and

WHEREAS, The medical profession believes that any national program should build upon the strengths of our present system of health care delivery, without detrimental and radical restructuring, but offering a variety or pluralistic means of health care delivery; and

WHEREAS, One bill introduced in the Congress and known as Medicredit (S.4444 and H.R. 2222), formulated by the American Medical Association, embodies beneficial and essential principles which should be embraced within a program for national health insurance; therefore be it

*Resolved,* That the Mississippi State Medical Association does hereby endorse the Medicredit program and does further recommend that the following basic Medicredit concepts be considered in any national health insurance:

That individuals should have available to them insurance protection, underwritten by risk bearing insurance companies, providing comprehensive basic health protection and also including protection against the catastrophic costs of illness;

That pluralistic means of health care delivery should be afforded, with the individual having the freedom of receiving care from qualified providers of his choice;

That any federal funding should be provided through general revenues, with government subsidy or assistance related to the individual's ability to pay;

That cost sharing by the beneficiary, while fostering individual responsibility, should be reasonable and not act to prevent access to health care;

That insurance policies or plans be qualified by appropriate governmental regulatory bodies; and be it further

*Resolved,* That this Medicredit endorsement and support for basic Medicredit principles be communicated to appropriate members of the Congress including members of the House Ways and Means Committee and the Senate Committee on Finance.

REPORT OF THE REFERENCE COMMITTEE  
ON REPORTS OF OFFICERS AND  
BOARD OF TRUSTEES

Your reference committee considered Resolution No. 7, introduced by Dr. C. D. Taylor, chairman, Council on Legislation, which states:

*"Resolved,* That this Medicredit endorsement and support for basic Medicredit principles be communicated to appropriate members of the

## HOUSE OF DELEGATES / Continued

Congress including members of the House Ways and Means Committee and the Senate Committee on Finance."

This resolution seeks the association's continued endorsement and support for the Medicare bill sponsored by the American Medical Association. We concur with this resolution and recommend its adoption.

The report of the reference committee was adopted.

### RESOLUTION NO. 8, PEER REVIEW

*Dr. G. Swink Hicks:* WHEREAS, Our Mississippi State Medical Association has acted to indicate its support of a peer review program; and

WHEREAS, Peer review is concerned with both the quality of medical care and its cost; and

WHEREAS, It is apparent from data brought to the attention of our Peer Review Committee that many third party payors do not understand the total peer review concept of concern for both quality and cost of health care; and

WHEREAS, Recent data concerning the activities of our Peer Review Committee reveals that all cases handled by the committee came from third party payors and most concerned questions of health care cost; and

WHEREAS, It is evident from data brought to the attention of our Peer Review Committee that many physicians do not realize that the peer review concept includes acting in their behalf, when requested, to resolve their differences with third party payors concerning health care cost and quality determinations made by such third party payors; and

WHEREAS, There is apparently a great need for further information concerning the peer review concept to be furnished to both physicians and third party payors; now therefore be it

*Resolved,* That the Peer Review Committee implement a concerted informational program for physicians through our JOURNAL MSMA and other communication mechanisms to inform physicians regarding the total peer review concept and to encourage them to submit grievances they have concerning quality and fee determinations made by third party payors; and be it

*Resolved Further,* That educational materials concerning the total peer review concept be furnished to all third party payors seeking to utilize the services of the peer review mechanism.

### REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered Resolu-

tion No. 8, Peer Review, introduced by Dr. G. Swink Hicks, Delegate to AMA, in behalf of the Adams County Medical Society, which states:

*"Resolved,* That the Peer Review Committee implement a concerted informational program for physicians through our JOURNAL MSMA and other communication mechanisms to inform physicians regarding the total peer review concept and to encourage them to submit grievances they have concerning quality and fee determinations made by third party payors; and be it

*"Resolved Further,* That educational materials concerning the total peer review concept be furnished to all third party payors seeking to utilize the services of the peer review mechanism."

Your reference committee feels that physicians in the state should be notified in every way feasible to submit grievances they have concerning fee determinations made by third party payors. It is felt that peer review should be a "two-way street" and that physicians should have access to the peer review mechanism to the same degree as third party payors. We, therefore, recommend adoption of Resolution No. 8.

The report of the reference committee was adopted.

### RESOLUTION NO. 9, PRISON HEALTH FACILITIES

*Dr. Jack A. Atkinson:* WHEREAS, The American Bar Association and the American Medical Association have joined together in a program to institute and improve medical and health services in the nation's correctional institutions, and

WHEREAS, The National Sheriffs' Association and the American Correctional Association are supporting the AMA's and ABA's efforts to develop a program to improve medical care and health services for the inmates of the nation's prisons, jails and juvenile detention facilities, and

WHEREAS, Recent surveys show that almost half of the nation's jails and prisons have no medical facilities, and

WHEREAS, The AMA and the ABA will be seeking the assistance of their state and local components in a program to survey, upgrade and certify local prison health facilities, now therefore be it

*Resolved,* That the Mississippi State Medical Association does associate itself with and support a program sponsored by the American Bar Association and the American Medical Association to institute and improve medical and health services in the nation's prisons, jails and juvenile detention facilities and be it

*Resolved Further,* That copies of this resolu-



tion be furnished to the Mississippi Bar Association and the Mississippi Sheriffs' Association.

#### REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Your reference committee considered Resolution No. 9 introduced by Dr. Jack Atkinson, Chairman, Council on Medical Services. The resolution states:

*"Resolved*, That the Mississippi State Medical Association does associate itself with and supports a program sponsored by the American Bar Association and the American Medical Association to institute and improve medical and health services in the nation's prisons, jails and juvenile detention facilities and be it

*"Resolved Further*, That copies of this resolution be furnished to the Mississippi Bar Association and the Mississippi Sheriffs' Association.

Your reference committee believes that this is a very needed and worthy endeavor and recommends adoption of Resolution No. 9.

The report of the reference committee was adopted.

#### RESOLUTION NO. 10, THE FACTS ON THE HEALTH CARE ECONOMY

*Dr. James M. Dabbs*: WHEREAS, Publicity on health care costs occurs at an increasing rate; and

WHEREAS, Such publicity often fails to truly identify the various components of the health care dollar and their relationship to the economy in general; and

WHEREAS, In fact the physician component of the health care dollar has decreased from 21.6 per cent of total health expenditures in 1960 to 19.0 per cent of such expenditures in 1971; and

WHEREAS, Such publicity often fails to identify the increase in demand for medical services due to enactment of Medicare, Medicaid and other government programs; and

WHEREAS, In fact such government programs now account for over 36.0 per cent of personal health care expenditures; and

WHEREAS, Average physician's charges for services under Medicare have declined 5.2 per cent for surgical services and 11.5 per cent for medical services since the program began in 1966; and

WHEREAS, Physicians' services under many state medicaid programs, including Mississippi's, are reimbursed under a payment schedule which bears no relationship to reasonable and customary charges and is in fact considerably less than such reasonable and customary charges; and

WHEREAS, Physicians' fees increased 2.1 per cent in 1972 which was below the 2.5 per cent goal set under the President's new Economic Policy and below the 3.8 per cent general cost of living increase during Phase II; and

WHEREAS, On January 11, 1973, mandatory wage and price controls were suspended for most sectors of the economy except the health care sector and we, as physicians, now pay for goods and services necessary to conduct our practices in an economy that has gone rampant; and

WHEREAS, Information on physicians' incomes often fails to identify such incomes after necessary practice expenses and often fails to identify that the average physician "work week" as indicated by Social Security Administration data is 62 hours, now therefore let it be

*Resolved*, That the Mississippi State Medical Association bring to the attention of our Congressmen, state officials and Legislators, and the public these facts on the health care economy, and be it

*Resolved Further*, That we as individual physicians bring these facts on the health care economy to the attention of our patients, and be it

*Resolved Further*, That a copy of this resolution be furnished to all state medical associations and they be respectfully urged to implement a similar program to present facts on the health care economy to the citizens of their respective states.

#### REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Your reference committee considered Resolution No. 10 introduced by Dr. James M. Dabbs, Delegate from Wayne County. The resolution states:

*"Resolved*, That the Mississippi State Medical Association bring to the attention of our Congressmen, state officials and Legislators, and the public these facts on the health care economy, and be it

*"Resolved Further*, That we as individual physicians bring these facts on the health care economy to the attention of our patients, and be it

*"Resolved Further*, That a copy of this resolution be furnished to all state medical associations and they be respectfully urged to implement a similar program to present facts on the health care economy to the citizens of their respective states."

Your reference committee believes that the facts on the health care economy contained in this resolution are facts that every physician should be discussing with their patients. As so

## HOUSE OF DELEGATES / Continued

well stated by Dr. Hoffman in his speech to this House on Monday "... our image is made in our offices with our patients." Your reference committee recommends adoption of Resolution No. 10 and recommends that a copy of the resolution be directed to the attention of each member of the association.

The report of the reference committee was adopted.

### RESOLUTION NO. 11, COMPOSITION OF MSMA BOARD OF TRUSTEES

*Dr. Charles O. Williams:* WHEREAS, The Central Medical Society seeks more just representation on the Board of Trustees of the Mississippi State Medical Association for its membership and the other physicians of District 5; now therefore be it

*Resolved,* That Central Medical Society does instruct its representatives to the 1973 House of Delegates to introduce and support an amendment to the constitution of the Mississippi State Medical Association to increase the membership of the Board of Trustees from 9 to 11. One of the newly created trustees would be elected from the membership of the West Medical Society of District 5 and the other newly created Trustee would be elected from the membership of the Central Medical Society of District 5. The existing trustee would be elected at large from District 5. The three year terms of office for the Trustees from District 5 are to be so arranged that one will be elected annually.

### REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

Your reference committee considered Resolution No. 11 introduced by Dr. Charles O. Williams, Delegate from Hinds County, in behalf of Central Medical Society. This resolution states:

*"Resolved,* That Central Medical Society does instruct its representatives to the 1973 House of Delegates to introduce and support an amendment to the constitution of the Mississippi State Medical Association to increase the membership of the Board of Trustees from 9 to 11. One of the newly created trustees would be elected from the membership of the West Mississippi Medical Society of District 5 and the other newly created trustee would be elected from the membership of the Central Medical Society of District 5. The existing trustee would be elected at large from District 5. The three year terms of office for the Trustees from District 5 are to be so arranged that one will be elected annually."

Your reference committee recommends that Resolution No. 11 be not adopted and be referred to the *ad hoc* study committee noted previously.

The report of the reference committee was adopted.

### RESOLUTION NO. 12, STATE MENTAL HEALTH DEPARTMENT

*Dr. Ellis M. Moffitt:* WHEREAS, The Mississippi State Medical Association (1) recognizes the need for a single state mental health agency, and (2) recognizes that mental health problems, though influenced by social, educational, environmental factors, et al, remain clearly a health problem; therefore, be it

*Resolved,* That the Mississippi State Medical Association supports the idea of a department of mental health and takes the position that the director of the department should be a qualified physician, preferably a psychiatrist, and be it

*Further Resolved,* That the Mississippi Psychiatric Association urges the adoption of this resolution and requests the House of Delegates of the Mississippi State Medical Association to encourage members of the association to support individually to their respective legislators the content of this resolution.

### REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered Resolution No. 12, State Mental Health Department, introduced by Dr. Ellis M. Moffitt, Delegate from Central Medical Society, at the request of the Mississippi Psychiatric Association, which states:

*"Resolved,* That the Mississippi State Medical Association supports the idea of a department of mental health and takes the position that the director of the department should be a qualified physician, preferably a psychiatrist, and be it

*"Further Resolved,* That the Mississippi State Medical Association urges the adoption of the resolution and requests the House of Delegates of the Mississippi State Medical Association to encourage members of the association to support individually to their respective legislators the content of this resolution."

In considering this resolution it was brought to your reference committee's attention that there are at present three separate state agencies having responsibilities in the mental health field. The programs and activities of these agencies are broad and complex, and certainly your reference committee is not qualified to state what is the best type of administrative system for these several activities and programs based upon one afternoon



of hearings. We, therefore, recommend the following substitute Resolve clause for Resolution No. 12:

*Resolved*, That the Mississippi State Medical Association believes that if a state department of mental health is created, that the director of such a department should be a qualified physician and that there should be strong physician representation on the department's governing board."

The report of the reference committee was adopted as amended.

#### OFFICIAL ATTENDANCE

The official attendance was announced as being 834 to include 394 members, 106 exhibitors (25 scientific), 86 guests, 8 medical students, 16 residents, 3 interns, 7 staff and 214 Auxiliary members.

#### REPORT OF THE REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

*Conduct of Business.* Your reference committee commends the Speaker and Vice Speaker for the outstanding manner in which they have conducted business before this House of Delegates. We believe that all members will wish to associate themselves in this expression of appreciation.

*Resolution.* The reference committee desires to offer the following resolution for consideration by the House of Delegates:

WHEREAS, The 105th Annual Session of the Mississippi State Medical Association has been conducted at Biloxi, Mississippi, during the period April 30-May 3, 1973, and

WHEREAS, The annual session has been most profitable and enjoyable for all who have been in attendance, now, therefore, be it

*Resolved*, That expressions of deep appreciation are made to the officers, Trustees and Council on Scientific Assembly for the stimulating and worthwhile scientific programs; to the management of the Sheraton-Biloxi for splendid services; to other participating hotels and motels; to the press, radio and television for coverage of our activities; to the gracious ladies of the Auxiliary who always contribute so substantially to our meetings; to the technical exhibitors and their professional representatives; to our scientific exhibitors who have contributed to our learning and instruction; to our distinguished guests, particularly Dr. Charles A. Hoffman of Huntington, West Virginia, president of the American Medical Association; and to all who have shared in the responsibilities of planning, organizing and conducting this great annual session.

Your reference committee recommends adoption of this resolution.

The report of the reference committee was adopted.

#### REPORT OF THE ELECTION OF OFFICERS

President-elect: J. T. Davis, Corinth.

Vice Presidents: Whitman B. Johnson, Clarksdale; William M. Gillespie, Jr., Meridian; and David M. Owen, Hattiesburg.

Secretary-Treasurer: James P. Spell, Jackson (1976).

Delegate to AMA: G. Swink Hicks, Natchez (1975).

Alternate Delegate to AMA: Stanley A. Hill, Corinth (1975).

Associate Editor: Myron W. Lockey, Jackson (1975).

Board of Trustees: James O. Gilmore, Oxford, District 2; Lyne S. Gamble, Greenville, District 1; and Robert S. Caldwell, Tupelo, District 3 (1976).

Council on Budget and Finance: Walter H. Rose, Indianola, and Sidney O. Graves, Natchez (1976).

Council on Constitution and By-Laws: Arthur E. Brown, Columbus (1976).

Judicial Council: James T. Thompson, Moss Point, District 9; William E. Weems, Laurel, District 7; and Wendell B. Holmes, McComb, District 8 (1976).

Council on Legislation: Ed Pennington, Ackerman, District 4; John G. Caden, Jr., Jackson, District 5; and George L. Arrington, Jr., Meridian, District 6 (1976).

Council on Medical Education: Charles N. Floyd, Gulfport (1976).

Council on Medical Service: Jack A. Atkinson, Brookhaven, District 8; Charles R. Jenkins, Laurel, District 7; and Bedford F. Floyd, Jr., Gulfport, District 9 (1976).

State Board of Health: Benton M. Hilbun, Tupelo; G. Leroy Howell, Starkville; and Lee H. Rogers, Tupelo—Nominees for District 1; and L. Stacy Davidson, Cleveland; John G. Egger, Drew; and Donald R. Ellis, Clarksdale—Nominees for District 3.

#### CLOSING CEREMONIES

There being no further business, the Speaker returned the gavel to President Jenkins. The Oath of Office was administered to Dr. Arthur A. Derrick, the president-elect, by Dr. J. T. Davis, chairman of the Board of Trustees, after which Dr. Derrick addressed the House of Delegates.

Dr. James Grant Thompson of Jackson presented the Thompson Memorial Past President's Pin to Dr. Jenkins.

The House of Delegates was adjourned *sine die* at 4:15 o'clock in the afternoon, May 3, 1973.

## Medical Clinics Assn. Plans Annual Meet

"The Linking of Education and Health Care Delivery"—an examination of the key elements in effective health care—will be the theme of the 24th Annual Meeting of the American Association of Medical Clinics, Sept. 16-20, 1973, at the Century Plaza Hotel, Los Angeles.

The AAMC is the national association representing all forms of group practice and group practice physicians. Delegates from the 10,000 member association will participate in general sessions, committee meetings, workshop groups, seminars and panel presentations during the five-day convention. Program Chairman is Dr. Loman C. Trover, a radiologist and medical director of the Trover Clinic, Madisonville, Ky.

The three general sessions will be Education, Health Manpower and Health Care Delivery.

Keynote speaker, Dr. M. Roy Schwarz of the University of Washington School of Medicine, will address the group on area health education. Discussion will focus on the need for constant re-evaluation of medical education and the role group practice can play in providing students a better socioeconomic understanding of community medicine.

Health manpower and the importance of physician recruitment and distribution will be presented by Dr. William R. Willard, dean of the College of Community Health Sciences at the University of Alabama. Emphasizing the critical relationship of health manpower and health education, the session will also direct itself to a consideration of the present status of the allied health personnel concept.

Dr. Merlin K. DuVal, Vice-President for Health Sciences at the University of Arizona, will discuss health care delivery and its importance not only to government and the general public but to members of the profession as well. Stress will be given to the group practice approach toward community and regional health care needs. Alternative views of health care delivery will be presented by American Medical Association president, Dr. Russell B. Roth, John W. Kauffman, chairman of The American Hospital Association Board of Trustees and Dr. Stanley S. Peterson, president, American Federation of Physicians and Dentists.

Multiple workshop sessions on matters of con-

cern to group practice physicians will be conducted. Topics to be included are: Allied Health Manpower; Physician Recruitment; Income Distribution and Fringe Benefits; Clinic Administration; Medical Records; Medical Auditing; and Integration of Capitation into Fee-for-Service groups.

In addition to panel presentations on Community Level Medical Education, Patient Education, Role Expectations of Allied Health Personnel and the Impact of Politics on Medicine, seminars will be held for multi and single specialty groups to discuss problems relevant to various clinic sizes and specialties.

Other guest speakers highlighting the convention will be Dr. William I. Bauer, director of Professional Standards Review for HEW and Dr. William R. Roy, Democratic Congressman from Kansas and co-sponsor of the House of Representatives' Health Maintenance Organization bill.

## Cardiology Course Set for Houston

A postgraduate course entitled, "Coronary Artery Disease—1973," will be held at the Texas Medical Center in Houston, Oct. 3-5, 1973.

The course is sponsored by the American Heart Association's Council on Clinical Cardiology, Baylor College of Medicine, and its affiliated hospitals, in cooperation with the AHA Texas affiliate and its Houston chapter. Drs. Robert J. Luchi and Henry D. McIntosh are the course directors.

The course will be concerned with recognition and therapy of common cardiovascular disorders. Emphasis will be placed on the application of new knowledge to diagnosis and treatment. Basic science concepts as applied to clinical problems will be discussed. Afternoon workshops and panel discussions will highlight material presented in the morning lectures.

Registration fee is \$120 for Fellows, Associate Fellows and members of AHA's Council on Clinical Cardiology, and \$170 for non-members. This includes luncheon, cocktails and dinner on Wednesday, and luncheon on Thursday and Friday.

Further information may be obtained from George E. Stewart, Jr., American Heart Association, 44 East 23rd Street, New York, N. Y. 10010.



# Medical Consent Law For Minors Proposed

A model law which would give doctors the right to treat certain minors—including those seeking treatment for pregnancy, venereal disease, and alcohol or drug abuse—without the consent of their parents or guardians has been proposed by the American Academy of Pediatrics' Committee on Youth.

The model act, "drafted with the purpose of stimulating all states of the union to review their statutes in regard to minors' consent for health services," appears in the February issue of *Pediatrics*, the AAP's monthly scientific journal.

The committee said the model act "accepts the concept that getting health services is a basic right. Also, it accepts that parents have their basic right of protecting and promoting the health and welfare of their minors."

"Therefore," the committee said, "This act is a compromise and a balance of these two basic rights in the conditions specified."

"The goal of this act is to insure that all minors can have quality health services by granting the minors self-consent in conditions and instances that will prevent them from seeking services if parental consent is required and by encouraging health professionals to deliver quality services to minors without incurring legal liability."

"Reasonable safeguards and limitations are stipulated in this act to protect the minors' safety and the right of the parent. The act also emphasizes the promotion of family harmony and minor's maturity."

According to the model act, a minor may give his consent for health services if he:

is or ever was married, has had a child, or has graduated from high school;

has been separated from his parents or guardian for whatever reason and is supporting himself by whatever means;

has physical or emotional problems and is capable of making rational decisions, and his relationship with his parents or guardian is such that by informing them he will fail to seek initial or future help. The law says that "after the professional establishes his rapport with the minor, then he may inform the parent, parents, or legal guardian unless such action will jeopardize the life of the patient or the favorable result of the treatment."

In the case of treatment for pregnancy, venereal disease, and alcohol or drug abuse, the act says that "self-consent applies only to the prevention,

diagnosis, and treatment of those conditions specified in this subsection. The self-consent in the case of pregnancy, venereal disease, and drug and substance abuse also obliges the health professional, if he accepts the responsibility as the provider of the health service, to counsel the minor by himself or by referral to another health professional for counseling."

Under the law the doctor may, but is not required to, tell parents or guardians about the minor's treatment when: severe complications are present or anticipated, major surgery or prolonged hospitalization is needed, failure to inform the parents would seriously affect the safety or health of the minor or the public, or informing parents would benefit the minor's physical and mental health and family harmony.

Such information can only be given, however, when the minor consents or when because of the minor's age or condition the doctor can presume such consent.

Other provisions of the proposed law include:

(1) Minors needing emergency care, including transfusions, may give their legal consent for such procedures. Parents shall be informed of the procedure "as soon as possible."

(2) Any minor who has had a child may give consent for health service for his child.

(3) Any minor may give consent for health services for his spouse.

(4) If major surgery, general anesthesia, or a life-threatening procedure has to be undertaken on a minor with his consent, the physician must obtain approval from another physician, except in emergencies where another physician is not available.

(5) Self-consent of minors shall not apply to sterilization or abortion.

(6) Except by specific legal requirement, no information about venereal disease, drug and substance abuse, pregnancy, and emotional illness shall be given by the doctor to another health professional, school, law enforcement official, court authority, government agent, spouse, employer, or any other person without the consent of the minor.

## WOMAN'S AUXILIARY (*Continued*)

We're FIFTY YEARS OLD. We're going strong and feeling great! And just like those wonderful wives of '23 who went before us to found the Mississippi Medical Auxiliary, we want to spend our *next* fifty years with you!

JANE PRESTON  
(Mrs. William H. Preston, Jr.)  
President, Woman's Auxiliary

## Southern Medical Will Meet in San Antonio

More than 6,000 physicians and paramedical personnel are expected to gather in San Antonio for the 67th Annual Meeting of the Southern Medical Association (SMA) scheduled for the Convention Center Nov. 11-14.

General chairman on arrangements for the convention is Dr. John J. Hinchey, orthopedic surgeon of San Antonio, and a member of the Bexar County Medical Society, host for the meeting.

The SMA meeting is held annually to help keep physicians up to date on the latest methods, medicines, research findings and advances in equipment and technology, and offers a variety of medical and scientific programs.

"In New Orleans last year, our convention registration exceeded 6,000 and we expect even more this year," Dr. Hinchey said. "We have an excellent four-day program with some of the outstanding physicians of the nation participating."

Officers of SMA are Drs. Joe T. Nelson, Weatherford, Tex., president; George J. Carroll, Suffolk, Va., president-elect; Woodard D. Beacham, New Orleans, La., first vice president; Robert F. Butts, Birmingham, Ala., executive director; and Harris D. Riley, Jr., editor of the *Southern Medical Journal*.

More than 200 scientific and technical exhibits will be of major interest to physicians, and addresses by 21 distinguished guest speakers will highlight the conference where physicians and others in the medical profession from throughout the South will gather to hear lectures covering all phases of medicine and take part in panel discussions.

Lunch and Learn sessions, sponsored by the various specialty sections, are always an important part of the annual meetings. These sessions feature outstanding moderators and topics of interest for all physicians.

Meeting conjointly with SMA will be several distinguished medical groups: the American Fertility Society; Radiological Society of North America; and Southern Gynecological and Obstetrical Society.

The scientific program will include postgraduate courses on facial trauma; emergency medicine; American Fertility Society; surgical infections; orthopedic nurses; Radiological Society of North America refresher courses; and dermatology postgraduate courses.

Although the convention is concentrated on medical and scientific programs, a number of social functions have been planned for SMA members. The annual golf tournament, alumni reunions and special activities for the Woman's Auxiliary, including sightseeing tours and luncheons; as well as the President's Dinner Dance, the entertainment special of all SMA annual meetings, will give the visiting physicians and their wives ample opportunity to relax from the more serious side of the convention.

The SMA Annual Meeting is open to all physicians, residents, interns, medical students, nurses, technicians and other paramedical personnel.

## Amphetamines May Cause Growth Suppression

The long-term use of certain drugs in the treatment of hyperactive children can lead to "a highly significant suppression of growth in weight and height," two researchers have reported in the April issue of *Pediatrics*, the monthly scientific journal of the American Academy of Pediatrics.

Dr. Daniel J. Safer and Richard P. Allen, Ph.D., said the study of 63 hyperactive children indicated that the amount of growth suppression depended on the type of drug given, the amount of the dose, and the frequency of use.

Of the children involved in the study, 29 were using dextroamphetamine sulfate (Dexedrine), 20 children were on methylphenidate (Ritalin), and 14 hyperactive children received no medication at all, because of parental objections.

The study, which involved measuring growth over several years, showed:

"The 29 children on dextroamphetamine were on medication for an average of 2.9 years and had an average loss of 20 percentile points in weight and 13 points in height. The 20 children on methylphenidate were on medication for an average of 3.0 years and showed smaller losses of 6 percentile points in weight and 5 in height. The 14 hyperactive controls not on medication showed small increases during the 4.2 years that their growth was followed."

The dosage of Ritalin, the researchers said, was crucial to the amount of growth suppression. When children were given 20 mg daily or less (the customary minimal effective dose), growth suppression differed little from children who received no medication at all. But "the high dose methyl-



phenidate groups showed weight and height (suppression) similar to—though less than—the dextroamphetamine group.”

For the children on dextroamphetamine, on the other hand, the significant factors in growth suppression were the duration of treatment and the frequency of drug administration.

“These results support the general proposition that the less stimulant medication the hyperactive child receives, the less likely his growth is to be suppressed,” the researchers wrote. “Since the drugs are mainly prescribed to benefit the hyperactive child in the classroom, it is preferable—when possible—to limit their use to cover that period.”

Overall, the children on Dexedrine achieved only 62 per cent of their expected weight gain and 75 per cent of their expected height gain. For children on Ritalin, the growth suppression averaged out to an 83 per cent rate of expected annual growth for weight and height.

The researchers said more study was needed regarding growth “rebound” in children who are taken off the amphetamines during summer months when school is not in session.

“However,” they said available data indicated that “the rebound growth does not entirely compensate for the growth deficit induced by dextroamphetamine during the academic year.”

“Although the finding that the long-term use of stimulant drugs can cause suppression of growth in hyperactive children has caused some concern,” the report concluded, “it is nonetheless important that the evidence on this matter be available to physicians.

“Only then will they be able to accurately assess—for each child, for each drug, for each dose—which is less hazardous to the patient; his illness, or the treatment. At this time, in general, the hazard of the illness appears to be more dangerous.”

## Vitamin D Supplement Not Needed by Most

Infants, pregnant women and nursing mothers may need an extra dose of Vitamin D. Other people most likely already get more than enough.

This is the report of an Alabama physician researcher in the June 11 issue of the *Journal of the American Medical Association*.

The communication, by Dr. Paul A. Palmisano of the University of Alabama Medical Center at Birmingham, is the first in a series of short articles that will appear in the *Journal* to help physicians fill a gap in their medical knowledge in the area of nutrition.

Most commercial milks, baby foods, margarines and breakfast cereals are fortified with Vitamin D, Dr. Palmisano writes. When this is added to Vitamin D obtained from exposure to sunlight, plus that *naturally* present in foods, the average American may receive several times the daily amount of Vitamin D he requires.

Extra pills on top of the naturally acquired supply of Vitamin D may prove too much for the normal person to handle. The result may be nausea, vomiting, constipation, excessive urination, excess thirst, dehydration and general weakness.

Vitamin D is essential to prevent rickets, a crippling bone disorder, in children. This fact has been known for many years, hence the fortification of some common foods. Nutritional rickets now is rare in the United States.

Most persons, says Dr. Palmisano, get all the Vitamin D they need from intermittent exposure to sunlight plus eating the ordinary American diet, “except the recluse who is also a strict vegetarian.”

Members of dark-skinned races will get less of the vitamin from sunlight than light-skinned persons, he adds.

In an accompanying editorial, Philip L. White, Sc.D., director of the AMA's Department on Foods and Nutrition, points out that “studies undertaken to evaluate what medical students and physicians know about nutrition reveal that both have a reasonable comprehension of the biochemistry of digestion, absorption and metabolism, but no real awareness of the food sources of nutrients. The translation of the science of nutrition into practical answers to a patient's questions is weak.”

Means must be found to communicate the necessary information to the physician and motivate him to utilize it in his practice, Dr. White says.

The series currently appearing in the *Journal* will be one of many programs of the AMA Council on Foods and Nutrition to help keep the physician up to date. The articles will deal with myths in the dietary management of intestinal disorders, consumer knowledge of nutrition, reducing diets, nutrition in pregnancy, and other topics of the moment, he says.

## Personality Traits Predict Drug Use

Junior high school students who get poor grades and flout school rules are significantly more likely to use drugs during their high school years than are their more studious and orderly classmates.

This is among the findings of a continuing five-year study of Boston elementary, junior high and high school students reported at a recent seminar at the National Institute of Mental Health.

The study is being conducted by Dr. Gene M. Smith of Massachusetts General Hospital, under a grant from NIMH, a component of HEW's Health Services and Mental Health Administration.

The longitudinal study seeks to determine: (1) why some students become regular drug users, while others experiment with drugs or ignore them; (2) how personality traits and academic performance serve as predictors of involvement with or disinterest in drugs; and (3) what changes occur in attitudes, personality, and behavior after the initiation of drug use.

Students tested are a sample of a predominantly white, middle class school population of 15,000 in 33 public schools in the greater Boston area. They range from fourth-graders to high school seniors, and when they fill out questionnaires each year, they rate themselves on traits of personality and behavior, and identify their attitudes toward and their use of drugs. School records furnish histories of academic performance. A coding system guarantees confidentiality. Although participation is voluntary, approximately 95 per cent of students present on testing days have taken part in the study.

In findings to date, the best indicator of subsequent use of illegal drugs is rebelliousness toward authorities and rules. Obedient children are the least likely to become drug users. The more rebellious a child, the greater his subsequent use of drugs is apt to be, ranging upward from infrequent marihuana smoking through frequent marihuana use to multiple experimentation and use—in addition to marihuana—of depressants, stimulants, LSD and other hallucinogens, and heroin.

Other reliable predictors of future drug use are classroom apathy and generally poor academic performance from middle grade school onward, and the early smoking of cigarettes. Indicative personality traits on which drug users score low are: conscientiousness, dependability, striving for recognition, setting high goals, persistency, plan-

fulness, thoroughness, efficiency, mannerliness, and agreeableness. Two traits which do not predict future drug use or non-use are vigor and self-confidence.

Use of alcohol parallels the use of drugs: heavy marihuana smokers are heavy drinkers, and the study finds no evidence to support the belief that different generations use different drugs ("the parents drink, and the kids smoke") and that marihuana use might for many supplant drinking.

While there are notable differences in personality between those students who have never used drugs and those who have, infrequent and frequent drug users tend to have similar personalities.

## Gastroenterology Course Scheduled

The American College of Gastroenterology announces that its Annual Course in Postgraduate Gastroenterology will be given at The Biltmore Hotel in Los Angeles, Calif., Oct. 25-27, 1973, immediately following the 38th Annual Convention of the college which will also be held there Oct. 22-24.

The course will be devoted primarily to review and assessment of newer developments in the diagnosis and management of gastrointestinal diseases.

A distinguished faculty, with knowledge and experience in the various disorders to be considered, will present the important advances that have special pertinence to clinical practice.

Close association between those enrolled in the course and the faculty will be encouraged by direct questioning after each discussion, as well as by a series of Special Round Table Discussions. The latter will consist of intimate, informal discussions between small groups of those taking the course and a member of the faculty with the former given the opportunity of selecting the topic of discussion each individual prefers. There will also be special reviews of the Self-assessment Program in Gastroenterology (American College of Physicians). These will consist of informal analysis and discussion, by the faculty and reviewers and those enrolled, of the questions posed and the appropriate answers to each.

A special lecture, summarizing the applied physiology of the gastrointestinal hormones that have come into prominence, is another feature of the course.

Information and enrollment may be obtained from: The American College of Gastroenterology, 299 Broadway, New York, N.Y. 10007.



# JOURNAL

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SEPTEMBER 1973

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Volume XIV  
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 September 1973



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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$7.50 per annum; \$1 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri.

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# Pinworm therapy is often a family affair



**Contraindications:** History of hypersensitivity to thiabendazole.

**Warnings:** If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.

**Precautions:** Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction,

patients should be carefully monitored.

**Adverse Reactions:** Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopenia; malodor of the urine, crystalluria, hematuria; appearance of live *Ascaris* in the mouth and nose. Hypersensitivity reactions





ORIGINAL PAPERS

## Wound Healing: A Review

MICHAEL P. BROOKS, M.D.

Jackson, Mississippi

TO THE SURGEON and the patient the most important quality of an incisional wound is its tensile strength.<sup>1</sup> The healing of an uncomplicated incisional wound is by primary union and involves three phases. The first, or substrate phase, lasts from the time of incision to the fourth to sixth day. During this time the inflammatory reaction prepares the wound for subsequent healing by removal of debris, necrotic tissue and bacteria. Proper irrigation of surgical wounds just prior to closure and the expert use of drains where needed will shorten this first phase. It is also during this period that sutures serve their most useful function in keeping wound edges closely approximated.

At about day four to day six ingrowing fibroblasts begin to lay down the building blocks, collagen, mucopolysaccharides, and glycoproteins, which quickly aggregate into fibers. Following this the wound rapidly gains tensile strength. Collagen will cease to increase in amount on about the fifteenth day, and there is a gradual transition into the third, or maturation phase, when the new collagen fibers become organized and contract. Over a period of months the scar will lose its pink color as capillaries decrease in number.<sup>2</sup>

Wound healing by secondary union involves these same principles with the main difference being replacement of a loss of tissue substance. Healing involves an open surface which must be filled with granulation tissue that can usually be detected on the second day, assuming there are no complicating factors. Because of its cellularity a granulating surface has a remarkable ability to resist infection. For the same reason crystalline

substances are rapidly absorbed through it. Epithelium will grow inward from the edge in two to three days if the dermal defect is not large.<sup>3</sup>

---

*In recent years there have been many innovations in the techniques of surgical wound closure. These new developments, coupled with a better understanding of the physiological basis of the healing process, have provided the surgeon with alternative management regimens previously unavailable. This paper reviews the physiology of wound healing, methods of wound closure, factors which stimulate or retard wound healing and the role of nutrition in the healing process.*

---

Healing by third intention is simply surgical closure of an open granulating wound and primarily speeds the total healing process by approximating epithelial edges with suture, tape, etc.<sup>4</sup>

The detrimental effects of ascorbic acid deficiency and protein depletion on wound healing are well established.<sup>5</sup> The particularly beneficial effects of methionine administration in protein depleted animals were first reported by Localio et al (1948) and later confirmed by Udupa et al (1956). However, protein deficiency is probably a relatively rare cause of delayed wound healing in the American population.

On the other hand, an excellent study of ascorbic acid in wound healing by Schwartz suggests that surgical patients may require more ascorbic acid than healthy persons.<sup>6</sup> Besides the fact that many postoperative patients are NPO and receive

---

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no vitamin C with their intravenous fluids, it is known that the body loses ascorbic acid after major surgery and other stresses such as burns and bacterial infections.<sup>7</sup> The current recommended daily dose for healthy adult men is 60 mg in the U. S. In Great Britain the recommended daily dose is only 30 mg.<sup>8</sup> Crandon et al. recommend 200 to 300 mg ascorbic acid per day for surgical patients. However, the data relating dosage to the quality of healing are by no means conclusive.<sup>9</sup>

The role of zinc in wound healing has been studied widely, but not thoroughly, in recent years and authorities have had varying results with its use. Zinc is an essential micronutrient in man and a relative preponderance of total biologic zinc is concentrated within the skin and cutaneous structures.<sup>10, 11</sup> Henzel et al measured zinc levels sequentially in serum, red cells, and urine in a variety of preoperative, postoperative, and healthy persons. They found urinary zinc losses markedly increased following surgical procedures but even greater losses after severe burns than after major surgical operations. Also, healing wounds in all patients were found to preferentially sequester biological zinc, even in the face of increased urinary losses. The zincuria in all patients was commensurate in magnitude with the metabolic insult or injury. Zinc deficiency was identified in 16 patients studied for impaired wound healing. The addition of supplemental dietary zinc in these patients resulted clinically in improved wound healing. The conclusions of this study were that zinc participates in certain biochemical processes which precede or underlie histogenesis of wound repair, and the efficiency with which these processes are able to function during wound healing is probably dependent on the local sufficiency of zinc.<sup>12</sup> For those who wish to give supplemental zinc, a safe dosage is 200 mg. three times a day with milk. Although it is tempting to believe that the administration of supplemental zinc to patients with normal zinc levels will actually accelerate wound healing, this has not been proven.<sup>13</sup>

Other researchers, after less intensive and well planned studies than the above, have found that zinc may be particularly important in the healing of leg ulcers.<sup>14, 15</sup>

## WOUND CLOSURE

There are two basic types of sutures, absorbable and nonabsorbable, and the choice of either should be based on the need at hand.

Absorbable sutures, commonly termed "cat-gut," are actually made from sheep intestines. In most cases, depending on the vascularity of the

wound, plain gut sutures are solubilized by tissue collagenase in seven to 14 days. Chromicized gut sutures will usually remain intact from three weeks to two months, again depending on wound vascularity.

In general, absorbable sutures are indicated in closure of loose nontension bearing tissues, when infection is known to be present, when debridement has been difficult or its thoroughness is in doubt, and in areas where a foreign body cannot be tolerated for other reasons.<sup>16</sup>

The ideal nonabsorbable suture should be completely inert, have maximum tensile strength per diameter, be easy to use with maximum pliability, and be available in all sizes. There are still four basic types: metallic wire, natural and synthetic fabrics, monofilament and woven synthetics, and varying combinations of fabric coated with synthetic plastic-like materials.

In a study comparing the tensile strength of wounds sutured with stainless steel wire, copper wire, cotton thread and silk, better and stronger healing was observed in the wounds sutured with stainless steel wire.<sup>17</sup> Tensile strength was measured on the seventh and twelfth postoperative days. On the seventh day no significant difference was observed between the cotton, silk, and copper wire. At this time the stainless steel wire was superior to the cotton. On the twelfth day the stainless steel wire was superior to cotton, and the cotton was superior to the silk and copper wire. Histologically, wounds sutured with stainless steel wire had the highest collagen content and those with copper wire had the lowest, probably because of the cytotoxic properties of copper. Wounds with stainless steel wire also had the fewest inflammatory changes.

A comparison of the tensile strength and tissue reaction of silk, cotton, dacron, nylon, and polypropylene sutures was made over a two-year period. Silk and cotton gradually lost tensile strength; silk was absorbed at a variable rate. Nylon decreased moderately in tensile strength but caused the least tissue reaction. Polypropylene maintained good tensile strength and showed low tissue reaction. The dacron retained good tensile strength and caused a moderate tissue reaction.<sup>18</sup>

Since all sutures are foreign bodies which elicit some degree of inflammatory reaction, early removal should be advantageous if it does not lead to dehiscence. Experimentally, incisions from which sutures were removed on the fourth day were stronger than those in which they were left in place for seven, suggesting that a certain amount of tension on healing wound edges is a stimulant to development of tensile strength.<sup>19</sup>



This is in keeping with other studies<sup>20</sup> demonstrating that a reduction in tension in a healing skin incision will produce a wound with less tensile strength.

Recently, the use of tape for closure of surgical wounds has become popular in some areas. At San Francisco General Hospital 428 wounds were analyzed, 161 closed with tape and 267 with conventional suture. The wounds were mostly abdominal, did not include hairy areas, and were classified in three groups as clean, clean-contaminated, or contaminated. Briefly, it was found that in the clean-contaminated group (e.g. operations such as cholecystectomy where a contaminated hollow viscus is opened), the use of tape closure was superior over conventional suture in that there were fewer postoperative complications such as superficial wound infection.<sup>21</sup>

Other studies indicate that tensile strength may be increased markedly by tape closure but extension may be reduced and energy absorption unaffected when compared with other methods of closure. Thus, despite the higher tensile strength of the tape closed wound, it may have no functional advantage over the sutured one.<sup>22</sup>

The remaining method of surgical wound closure involves the use of tissue adhesives. There are several types all of which function in a basically similar fashion. The most widely used at this time are probably the cyanoacrylate monomers. Hatung reported superior results over conventional sutures when using this for closure of wounds of parenchymatous organs, but not for closure of skin wounds.<sup>23</sup>

Other studies comparing aerosol isobutyl cyanoacrylate spray and 3-0 silk for closure of 10 cm skin incisions revealed the following: Bridging of the incised area by fibroblasts and capillary buds was inhibited by the thin film of artificial adhesive for at least two weeks after incision. At two weeks, suture-closed wounds could not be separated whereas parts of the adhesive-closed wounds could be. Furthermore, the tensile strength of the adhesive-closed wound exceeded that of the silk-closed wound from day one through day four after which this relationship was reversed.<sup>24</sup>

Hence, the presence of polymer fragments between the incised skin edges does delay wound healing, but the appearance of the healed wound is cosmetically superior to one closed with suture.<sup>25</sup>

Many attempts have been made to isolate factors, both biological and synthetic, which will facilitate and enhance the normal healing processes present in healthy tissue. For the most part, these have been discouraging. However, the findings of

Alexander, et al<sup>26</sup> suggest that cellular proliferation at sites of tissue injury results from release of biologically active mediators from lysosomes of injured or dead cells, including neutrophils sequestered in injured tissues. It has been shown that cartilage extracts can increase the rate of healing in normal animals.<sup>27</sup>

Prudden et al<sup>28</sup> have found n-acetyl-glucosamine obtained from shrimp chitin to be an effective accelerator of wound healing.

According to Rosen et al.<sup>29</sup> ultrafiltrates of wound fluid contain a growth-stimulating substance.

One of the most encouraging studies incorporated the use of enriched collagen solutions in a controlled series of uncomplicated wounds. Three days postoperative, swelling, hemorrhage, and inflammation were conspicuously reduced when compared with controls. Eventually, the enriched collagen solutions were completely removed from the wound. This, along with the low antigenicity of collagen, may make it easier to use clinically.<sup>30</sup>

The significance of these and other recent findings is still in doubt, but it is apparent that if factors do exist which can truly accelerate wound healing they will probably be biologic and not synthetic.

## DETERRENTS TO HEALING

Infection in surgical, burn or traumatic wounds is a result of interaction of the number and the characteristics of the contaminating organisms and of local and systemic host resistance factors. These factors are influenced by the epidemiological characteristics of bacterial populations, especially in surgical wounds. Also, the type and duration of operation, the patient's age, and his general health affect both local and systemic resistance to infection.<sup>31</sup>

The bacterial flora of normal human skin consists of relatively few species. Of these, the only true pathogen consistently present is *Staphylococcus aureus* which may be found in almost all regions of the skin. *S. epidermidis* is more prevalent but only occasionally pathogenic. Pathogenic gram-positive streptococci are rare on the skin, and gram-negative organisms are also relatively rare on normal skin.<sup>32</sup>

The number of organisms which initially contaminate a wound is very important in that most species exert pathogenic effects only after they reach a critical number. Staphylococci and other indigenous bacteria rarely invade skin without some preceding insult to the tissue. This is borne out by the fact that only several hundred rather than several million bacteria are needed to pro-

duce a pustular lesion when introduced with a silk suture.<sup>33</sup>

In many hospitals staphylococci are still the most common single infecting agent, with the gram-negative organisms becoming increasingly more frequent. The predominance of staphylococci is probably due to the fact that it is virtually impossible to achieve complete sterility of the skin by the usual scrubbing techniques. In one study of 50 patients, coagulase-positive staphylococci were cultured from the wound prior to closure in 92 per cent of cases. They were found in the air of the operating room in 68 per cent, and in 50 per cent of the cases they represented the patient's own carrier strain. Therefore, the chief source of wound contamination occurring at the time of surgery appears to be the patient's own skin.<sup>34</sup>

Other potential sources include the surgeon and his assistants, non-sterile instruments, and bacteria introduced by polyethylene intravenous catheters.<sup>35</sup> Finally, a great number of secondary factors may, if present, predispose to clinical infection. Two which should always be avoided are insufficient irrigation of the wound just prior to closure and sutures which are tied so tightly they strangulate living tissue. When devitalized tissue fragments and clotted blood are not irrigated from the wound they may act as a nidus for clinical infection. Likewise, tissue strangulated by sutures will behave as devitalized, dead tissue, aggravated by the fact that it is surrounded by a suture which can act as a foreign body.

## TRAUMATIC WOUNDS

Schwartz, et al state that the most important single factor in the management of contaminated wounds is adequate debridement.<sup>36</sup> This includes removal of foreign matter as well as devitalized tissue and is best done with sharp debridement and hemostasis followed by irrigation with copious amounts of saline. It has been shown that the incidence of wound infection is inversely proportional to the amount of irrigation and debridement done at the time of injury.<sup>37</sup> Lyman, et al found a close correlation between the rate of healing of infected wounds and the bacterial populations in them.<sup>38</sup>

The chance of wound contamination is, of course, greater when the wound is traumatic rather than surgical. However, a study of minor industrial wounds revealed the infecting staphylococci to be the patient's own carrier strain in 50 to 60 per cent of cases.<sup>39</sup>

The anaerobic bacteria are no longer a common threat in deep tissue wounds, since the ad-

vent of tetanus toxoid and early debridement with delayed closure. Recent military reports on the most common infecting agents in this type of wound implicate staphylococci, *Pseudomonas*, and *E. coli*.<sup>40</sup>

The treatment of contaminated wounds with early debridement and delayed closure deserves special emphasis. The effectiveness of these techniques in the treatment of military wounds in Vietnam is indicated by the low reported wound infection rate of 2.58 per cent.<sup>41</sup> An excellent study by Edlich, et al<sup>42</sup> revealed that the optimal time for closure of contaminated wounds, without inviting wound infection, is on or after the fourth postwounding day. The rate of wound infection varied from 73 per cent when closed after 24 hours, to 22 per cent when closed after 48 hours, 33 per cent when closed after 72 hours, and only one out of 30 after 96 hours.

## TOPICAL ANTIBACTERIALS

The ideal wound toilet in contaminated cases should include the use of irrigants which are bactericidal but do not damage living wound tissue. Many agents have been tried experimentally and several, though not ideal, have proven useful. Seventy per cent ethanol, benzalkonium, and iodide preparations can give significant protection, but silver nitrate may increase the infection rate.<sup>43</sup> Experimental crush wounds treated with topical antibiotic sprays and methenamine salts were found to heal better only if these agents were used within five minutes of contamination.<sup>44</sup>

Recent studies with betadine<sup>45</sup> (povidone-iodine) have proven it to be a powerful bactericidal agent against all species of bacteria while being relatively innocuous to living wound tissue with a pH of 7.4. It has few to no side effects, and is active in the presence of pus and organic matter. Also, it does not foster the emergence of antibiotic resistant strains.<sup>46</sup>

Recent studies of the popular topical antibacterial agent sulfamylon have shown that it definitely delays healing in open wounds because of its destructive effect on the three major cellular participants.<sup>47</sup> When the healing times of wounds treated with either xeroform gauze, silver nitrate, or sulfamylon were compared, the following results were obtained: Xeroform treated wounds averaged seven days, those treated with silver nitrate averaged 9.8 days, and the sulfamylon group averaged 12.5 days.<sup>48</sup> This is in keeping with clinical evidence that separation of a burn eschar is delayed when sulfamylon is used.<sup>49</sup>

It is interesting to note that although infection in a wound enormously inhibits its ability to heal, it is not necessarily desirable to have an absolutely sterile wound. The effect of the germfree state



on wound healing was studied by Donati, et al who found no significant differences in the rate of wound contraction when germfree and conventional wounds were compared, despite differences in the intensity of the inflammatory reaction.<sup>50</sup>

The overall effect of dehiscence and resuture on the rate of wound healing is controversial. Madden and Smith have found that in otherwise healthy wounds disruption merely causes a temporary change in wound strength with no apparent effect on the basic biochemical reactions that are responsible for the physical changes taking place. Dehiscence and resuture of a seven day wound did not alter the established rate of new collagen synthesis and deposition, and the total healing was essentially unchanged.<sup>51</sup>

Penicillamine is a metabolic by-product of penicillin. It is also a copper chelater and is known to decrease the tensile strength of healing wounds.<sup>52</sup> Seifter, et al reported a decrease in healing wound tensile strength in rats given large doses of penicillin G.<sup>53</sup> However, Pohl and Hunt found no decrease in wound tensile strength when rats were given intraperitoneal doses of penicillin G equivalent to the largest currently in clinical use.<sup>54</sup>

Tumoricidal radiation has certainly been implicated as a deterrent to active wound healing, and wound complications are very common in operative procedures following tumor radiation therapy. However, Thompson and Bennett found that after as much as 3,000 rads (a subtumoricidal dose) of cobalt 60 radiation completed two weeks prior to surgery there was no significant delay in epithelialization of the open wounds compared with controls. Ten days after wounding, the irradiated group did show a decrease in tensile strength, and after 12 days they showed a decrease in wound collagen compared with controls.<sup>55</sup>

A factor to be considered as a possible deterrent to wound healing is the method by which the surgical incision is made. The use of sharp cutting blades is time honored as the best method of dividing tissue with the least possible trauma and is mentioned only in comparison with some of the more modern methods. Hall found that skin incisions made with a carbon dioxide laser were substantially weaker than scalpel wounds up to and including 20 days after surgery. By 40 days the two groups had comparable tensile strength. The initial weakness was attributed to thermal necrosis of the wound margins. This was true to a lesser extent in skin wounds made with electrocautery units. Hence, the hemostatic properties of the laser and of electrocautery, when used for skin incisions, are offset by delayed healing. However, healing times were not significantly different

for the three methods when used in the deeper layers of the abdominal wall.<sup>56</sup>

## SUMMARY

The normal physiologic process of wound healing is carried out by either primary union, secondary union, or tertiary union. Every surgeon should have a thorough understanding of the basic principles involved in the body's responses to tissue injury and how they are affected by the more common factors which come into play in every surgical patient.

Wound healing is definitely delayed by diets deficient in ascorbic acid and methionine. The body's requirement for ascorbic acid is increased following surgery or trauma. Patients with a deficiency of total body zinc also experience delayed wound healing.

The three basic types of wound closure are with sutures, tapes, and tissue adhesive. The optimal time for removal of skin sutures in uncomplicated surgical wounds is on or about the fourth or fifth day. Proper tension on wound margins early in the healing process is important in establishing wound tensile strength. Tapes are indicated for closure of "clean-contaminated" surgical wounds. Wound closure with tissue adhesive results in delayed healing after the first four post-operative days, but cosmetically the end result is superior.

Several biologic factors appear to accelerate normal wound healing. None of these, however, has achieved sufficient clinical significance to warrant widespread use or commercial production. One of the most promising is ECS, or enriched collagen solutions.

Any factor which will inhibit growth of tissue will inhibit wound healing. The most common and most important single factor, from a surgical standpoint, is infection. Clean surgical wounds are almost never sterile, and when such a wound becomes septic the most common source of the infecting agent is the patient's skin, the single most common organism being *Staphylococcus aureus*. This is often the case in minor traumatic wounds as well.

When traumatic wounds are treated surgically with early debridement, delayed closure on or after the fourth day, and antibiotics selected on the basis of culture and sensitivity, the incidence of infection should be no higher than in clean surgical wounds.

When topical antibacterial agents are used on open wounds the potential benefits should be weighed against the damage they may cause to living tissue.

In the germfree state, wound healing does not

appear to be affected adversely or to be improved, as might be expected.

Experimentally, dehiscence and resuture of non-infected wounds does not appear to either retard or to promote healing in quality or in time.

The by-products of metabolized penicillin G probably do not inhibit wound healing, even when this drug is used in high doses.

Operative wounds will heal in a satisfactory manner, although more slowly, when as much as 3,000 rads of radiation have been received in the same area as late as two weeks prior to surgery.

The time-proven scalpel still appears to be superior to other newer instruments such as lasers and electrocautery for the vast majority of surgical procedures, especially for incising the skin.

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# Report of a Three-Year Study at the Mississippi Baptist Hospital Coronary Care Unit

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A SIX-BED Coronary Care Unit was opened at the Mississippi Baptist Hospital on June 16, 1969, and from that time through June 15, 1972, 1,569 patients were admitted to the unit. These patients were admitted to the Coronary Care Unit because of cardiovascular emergencies; all were not suspected to have acute myocardial infarctions. However, of the 1,569 admissions to the unit, there were 417 documented acute myocardial infarctions. The following criteria for infarction were used besides a history suggestive of myocardial infarction, i.e., chest pain for example:

1. (a) Diagnostic Q waves of 0.04 second duration were used for transmural infarction; (b) ST-T abnormalities which included ST-T depression of 1 mm or greater or symmetrically coved "ischemic" T wave abnormalities.

2. A transient rise in SGOT of 80 units or greater.

Eighty-six black patients, 1,482 white patients and one Indian were admitted to the unit. Only 21 blacks had evidence of acute myocardial infarction, compared with 396 white patients with acute myocardial infarctions. This is in keeping with the lower incidence of acute myocardial infarction in blacks and is usually associated with high blood pressure and/or diabetes.

There was a slightly higher incidence of myocardial infarction in the months of January through May (see Table I).

The incidence of anterior wall myocardial infarctions and inferior wall myocardial infarctions was similar (see Table II).

There were 40 deaths out of 417 documented acute myocardial infarctions or a mortality rate of 9.6 per cent over the three-year study period.

Anteroseptal myocardial infarction patients had a considerably higher mortality rate than those with infarctions involving other areas of the myo-

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*The Mississippi Baptist Hospital Coronary Care Unit was opened in June 1969. The authors report on the first three years of the unit's operation when 1,569 patients were admitted. They discuss the patients in regard to racial aspect, seasonal variation of myocardial infarction, localization of infarction, mortality, arrhythmias, conduction defects, cardiogenic shock, asystole and congestive heart failure.*

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cardium. This would lend support to the impression that disease of the left coronary artery, particularly the left main and proximal portion of the anterior descending branch, surely should be considered potentially more lethal than disease elsewhere in the coronary arterial circulation (see Table III).

Supraventricular tachycardias (atrial and nodal tachycardia, atrial flutter, and atrial fibrillation) were common. Ninety-five instances of these arrhythmias were found (see Table IV):

- (1) Atrial tachycardia occurred in 15 patients with inferior wall myocardial infarction and 27 patients with anterior wall myocardial infarction.

- (2) Atrial flutter developed in nine patients with inferior wall myocardial infarction and five patients with anterior wall myocardial infarction.

- (3) Atrial fibrillation occurred in 18 patients with inferior wall myocardial infarction and in six with anterior wall myocardial infarction.

These figures indicate that supraventricular arrhythmias were more common in our patients

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with inferior wall myocardial infarctions than in those with anterior wall myocardial infarctions. Potentially life-threatening arrhythmias, ventricular tachycardia and ventricular fibrillation, occurred in 88 of the patients with acute myocardial infarction. Ventricular tachycardia was equally frequent in inferior and anterior infarctions, but ventricular fibrillation was significantly more frequent in anterior wall myocardial infarctions (see Table V). In the 46 cases with ventricular tachycardia, there were three deaths. In the 42 cases of ventricular fibrillation, 18 patients lived and 24 died. These arrhythmias were generally managed with lidocaine and/or direct current countershock.

There was a total of 90 instances of atrioventricular block, 37 first degree atrioventricular block, 30 second degree atrioventricular block, and 23 third degree atrioventricular block. These

TABLE I  
MYOCARDIAL INFARCTIONS AS TO SEASON

Months	MI's
June	33
July	29
August	27
September	35
October	28
November	33
December	36
January	41
February	29
March	41
April	43
May	43
Total	417

TABLE II  
LOCALIZATION OF MI'S

Area of Infarction	
Anterior	160
Inferior	192
Subendocardial	50
Periapical	3
Basilar	1
Transseptal	11
Total	417

TABLE III  
TOTAL DEATHS OF MI'S

Area of Infarction	Total
Inferior	8
Inferolateral	1
Anteroseptal	23
Transseptal	4
Periapical	1
Subendocardial	3
Total	40

Mortality Rate: 9.6 per cent

TABLE IV

ATRIAL TACHYCARDIA

Area of Infarction	Total— 3 years
Inferior	11
Inferolateral	4
Anterior	6
Anteroseptal	15
Anterolateral	3
Transseptal	3
Periapical	2
Subendocardial	5
Total	49

ATRIAL FLUTTER

Area of Infarction	Totals
Subendocardial	1
Inferior	8
Inferolateral	1
Anterior	2
Anteroseptal	3
Transseptal	1
Total	16

ATRIAL FIBRILLATION

Area of Infarction	Totals
Inferolateral	3
Inferior	15
Anterior	2
Anteroseptal	4
Subendocardial	4
Transseptal	2
Total	30

occurred most frequently in inferior infarction (see Table VI). Temporary transvenous pace-makers were used in 14 patients with seven surviving (see Table VII).



Cardiogenic shock was considered to be present in those patients who were cyanotic, cold, clammy, mentally obtunded, and in whom the blood pressure was difficult or impossible to obtain by the usual auscultatory or palpatory methods. Mortality in this group was 81 per cent (see Table VIII). Cardiogenic shock occurred in nine patients with anterior wall myocardial infarction and in four patients with inferior wall myocardial infarction.

TABLE V

VENTRICULAR TACHYCARDIA	
<i>Area of Infarction</i>	<i>Totals</i>
Inferior	22
Inferolateral	5
Anterior	3
Anteroseptal	10
Periapical	1
Transseptal	2
Subendocardial	3
Total	46

VENTRICULAR FIBRILLATION

<i>Area of Infarction</i>	<i>Totals</i>
Inferior	14
Inferolateral	2
Anterior	7
Anteroseptal	12
Anterolateral	1
Transseptal	2
Periapical	1
Subendocardial	3
Total	42

TABLE VI  
CONDUCTION DEFECTS

<i>°AV Blocks</i>	<i>Area of Infarction</i>	<i>Totals</i>
1st °AV block	Inferior	26
	Anterior	3
	Anteroseptal	5
	Anterolateral	1
	Inferolateral	2
2nd °AV block	Inferior & lateral	21
	Anteroseptal	6
	Anterior	2
	Transseptal	1
3rd °AV block	Inferior	11
	Anterior	2
	Anteroseptal	5
	Transseptal	1
	Subendocardial	2
	Inferolateral	2
Total		90

TABLE VII  
TEMPORARY PACEMAKERS

<i>Area of Infarction</i>	<i>Totals</i>
Inferior	8
Anteroseptal	3
Transseptal	2
Anterior	1
Total	14
Died	7
Survived	7

TABLE VIII  
CARDIOGENIC SHOCK

<i>Area of Infarction</i>	<i>Totals</i>
Anteroseptal	6
Anterolateral	1
Inferolateral	4
Transseptal	1
Subendocardial	2
Anterior	2
Total	16
Died	13
Survived	3

TABLE IX  
ASYSTOLE

<i>Area of Infarction</i>	<i>Totals</i>
Anterior	6
Anteroseptal	2
Anterolateral	1
Inferior	1
Unknown	2
Subendocardial	1
Total	13
Total survived	2
Total died	11

Mortality Rate: 85 per cent

Asystole occurred in 13 patients (see Table IX). There were two survivors. Asystole occurred in nine patients with anterior wall myocardial infarction and only one with inferior wall myocardial infarction. Intraventricular conduction blocks with anteroseptal infarcts presumably cause this lethal arrhythmia.

Acute pulmonary edema occurred in 13 patients. This complication was much more frequent in anteroseptal myocardial infarctions than infarctions of other areas (see Table X). Seven survived and six died.

TABLE X  
PULMONARY EDEMA

<i>Area of Infarction</i>	<i>Totals</i>
Inferior .....	3
Anteroseptal .....	5
Subendocardial .....	1
Anterolateral .....	2
Intramural .....	1
Transseptal .....	1
Total .....	13
Total survived .....	7
Total died .....	6

We believe that the low mortality rate found was due in large part to the nursing care the patients received in the Coronary Care Unit and would compare favorably with other figures reported throughout the country. Also, there was a marked degree of cooperation among members of the medical staff of the Mississippi Baptist Hospital in moving patients to and from the unit; thus enabling more patients to be exposed to the high quality of care found there.

In addition, the administration of the Mississippi Baptist Hospital made every effort to provide the latest and most up-to-date facilities and equipment to be used in the unit.

It is hoped that with continued use of such units, the mortality and morbidity associated with acute myocardial infarction may be further reduced. ★★★

1151 North State Street (39201)

### SHOCK YET TO COME

The young husband had settled in his favorite armchair and started to read the evening paper. His wife of a few months was sitting opposite him.

Pulling out her knitting, she remarked shyly, "I went to see the doctor today."

He continued reading for a minute, then looking up he asked absently, "Oh did you, dear. . . . How is he?"

—*Standard Flashes*

### DEFINITE DEFINITION

Parking Space: an unoccupied area along the curb on the other side of the street.

—L. J. GOODYEAR



# Epistaxis: A Constant Perplexing Problem

DAVID M. DOAN, M.D.

Jackson, Mississippi

EPISTAXIS IS a relatively common occurrence among all age groups. Approximately 80-90 per cent of all nosebleeds stop without any treatment and without complications. The remaining need some form of local therapy. I stress the point of local versus systemic therapy (so-called clotting drugs) because I would like to emphasize that almost all non-traumatic nosebleeds are a consequence of local tissue problems that may or may not have been brought on by some systemic factor, usually not a clotting factor. This will be discussed further under therapy.

The etiology of epistaxis and site of bleeding is variable. In children almost all nosebleeds are of the anterior variety, most likely secondary to nose picking, occasional blunt trauma, and possibly a foreign body. The young adult displays mainly anterior nosebleeding, but the incidence of posterior epistaxis shows some increase. In the older age group (over 40) the incidence of posterior epistaxis becomes ever more increasing. In all age groups, especially the older group, the presence of malignancy should be considered in the differential diagnosis. Septal deviations, whether congenital or traumatic, can also be a cause of nosebleeds. They cause a variation in the airflow patterns in the nose and an excess drying of the mucosa over vessels in certain areas. This, in combination with some phenomena that cause an increase in vascular pressure (i.e. sneezing, coughing, or hypertension), can cause rupture of some intranasal vessels.

In the routine workup of patients with epistaxis we have found the most common pitfalls to be among the following:

(1) Inadequate prepacking evaluation and treatment.

Remedy—Most patients with epistaxis are not in hypovolemic shock, unless there are other bleeding sites. If patient is not shocky, usually 10-15 mg of Morphine Sulfate can be given to abate apprehension and help to lower the blood pres-

sure. Many patients with a mild bleed will have stopped by the time the physician arrives at the emergency room.

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*The author, UMC chief resident in otolaryngology, discusses the common problem of epistaxis in regard to etiology, site of bleeding and appropriate therapy. He also gives common pitfalls found in routine work-up of patients with epistaxis and the steps necessary to remedy each. The importance of taking care in the primary evaluation and packing of the nosebleed is emphasized.*

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(2) Inadequate or inaccurate nasal packing.

Remedy (a) Layered packing of sterile vaseline gauze in an accordion fashion to exert more pressure in small crevices.

(b) Both sides should be packed in an anterior bleeder because of the flexibility of the septum.

(c) Posterior packing is most easily applied, even by the inexperienced, with the use of a 30 cc Foley catheter inflated with 12-15 cc H<sub>2</sub>O. Posterior nasal pressure is exerted by anterior tension on this catheter anchored with an umbilical clamp anteriorly. Care must be taken to pad carefully between the clamp and the external nares to prevent necrosis.

(d) If posterior packs are used, anterior packs are needed.

(c) Classical posterior packs cannot be placed adequately without excruciating pain in the patient unless general anesthesia is used. We have one documented case of a myocardial infarct suffered by a patient getting a classical pack (i.e. lamb's wool, etc.) placed in posteriorly at the University Medical Center.

(3) Unsubstantiated dependence on systemic drugs to slow down or stop epistaxis.

Remedy—Several drugs have been marketed for many years as having hemostatic properties, such as Premarin, Adrenosem, and Vitamin K

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From the Division of Otolaryngology, University of Mississippi School of Medicine, Jackson, Miss.

preparations. Most of these have such a slow onset of action (varying from hours to days) that their benefit is of little consequence in the treatment of acute nosebleed. There may be some place for them, if a specific bleeding anomaly is identified after the acute bleed is controlled adequately. If no specific bleeding problem can be identified and the bleeding continues, ligation should be seriously considered.

## (4) Too much cauterization.

Remedy—Electrocautery and silver nitrate sticks (100 per cent) should be used on septal bleeders with extreme caution as septal perforation may occur secondary to avascular necrosis, thus creating a problem that is worse than the one corrected. These perforations, in most cases, cannot be surgically closed and cause recurrent epistaxis themselves and an occasional malpractice suit.

The physician should more properly do one or more of the following:

(a) Inject around the bleeding site with one per cent Xylocaine with 1:100,000 epinephrine.

(b) Pack the nose anteriorly bilaterally with sterile vaseline gauze.

(c) Perform light cautery with 25 per cent silver nitrate (or weaker).

If the nose is packed and bleeding is controlled, all packs are left in 48 hours. Hgb/Hct is drawn stat and is followed every 12 hours on hospitalized patients. The patient should be placed on sedative/pain combination, antibiotics, and de-

congestants. If hospitalized, IV fluid therapy should be maintained. If, after what is considered adequate packing and sedation by the attending physician, the bleeding continues, the patient should be considered for ligation of vessels, either in the OR at that hospital, if it is equipped with an operating microscope, or at some center which is equipped with one. We believe that this is a better policy than waiting for systemic drugs to stop the bleeding, especially if no specific bleeding anomaly has been determined.

The operations for nasal bleeding include ligation of the internal maxillary artery (posterior nosebleeds) and the ethmoid artery (high anterior nosebleeds). Silver clips are applied with the use of the operating microscope. The surgery is usually done under light general anesthesia; however, it could be done under local anesthesia. The morbidity of treating the patient this way is much less than having the nose packed for several days, and, in many cases, the hospital stay is decreased.

## CONCLUSION

In conclusion, the treatment of an epistaxis case can be a frightening task to almost anyone, especially the young and inexperienced, but if one will take care in the primary evaluation (including Hx, P.E. and lab) and packing of the nosebleed, not only will the physician feel more comfortable treating these patients, but this form of therapy will be more gratifying to the patient.

★★★

2500 North State Street (39216)

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## THE TRUTH OF THE MATTER

Husband, angrily to wife: "What do you know about money matters?"

"Only that it does," she replied sweetly.

—Copied

## SMALL BUT CONVENIENT

The new compact homes are remarkably convenient. If you are in the living room and want to go to the bedroom, you just stay where you are.





## MEETINGS

### NATIONAL AND REGIONAL

American Medical Association, Clinical Convention, Dec. 1-5, 1973, Anaheim, Calif. Annual Convention, June 22-27, 1974, Chicago. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Southern Medical Association, 67th Annual Scientific Meeting, November 12-15, 1973, San Antonio. SMA, 2601 Highland Ave., Birmingham, Ala. 35205.

### STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 11-13, 1974, Biloxi. Mrs. Alyce Palmore, Executive Secretary, P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 106th Annual Session, May 6-9, 1974, Biloxi. Charles L. Mathews, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday, March, June, September, December. James S. Poole, The Field Clinic, Centreville 39631, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Max Pharr, B6 Medical Arts Building, 1151 N. State St., Jackson 39201, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, P.O. Box 147, Port Gibson 39150, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday, April, and First Wednesday, November, 2:00 p.m., Clarksdale. Glenn L. Wegener, 1967 Hospital Drive, Clarksdale 38614, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September and November. J. H. Gaddy, 4502 15th St., Gulfport 39501, Secretary.

Delta Medical Society, Second Wednesday, April and October. Walter H. Rose, 122 E. Baker St., Indianola 38751, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Kenny's Res-

taurant, Hernando. Malcolm D. Baxter, Jr., Baxter Clinic, Hernando 38632, Secretary.

East Mississippi Medical Society, First Tuesday, February, April, June, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian 39301, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez 39120, Secretary.

North Central District Medical Society, Third Wednesday, March, June, September, and December. Robert B. Townes, 1196 Mound St., Grenada 38901, Secretary.

Northeast Mississippi Medical Society, First Thursday, March, June, September, and December. Jack A. Stokes, 207 Holmes Rd., Pontotoc 38863, Secretary.

North Mississippi Medical Society, First Thursday, April and October. Cherie Friedman, 1004 Jackson Ave., Oxford 38655, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. C. Griffing, Crosby Memorial Hospital, Picayune 39466, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, and December. W. C. Welch, P.O. Box 5448, Mississippi State 39762, Secretary.

Singing River Medical Society, Third Monday, January, March, May, July, September, and November. Jeff Hodges, 1365 Market St., Pascagoula 39567, Secretary.

South Central Mississippi Medical Society, Second Tuesday, March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb 39648, Secretary.

South Mississippi Medical Society, Second Thursday, March, June, September, and December. Larry J. Hammett, 2601 Mamie St., Hattiesburg 39401, Secretary.

West Mississippi Medical Society, Second Tuesday, January, April, July, and October, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, The Street Clinic, Vicksburg 39180, Secretary.

# Radiologic Seminar CXXXI: Pulmonary Mucoviscidosis

A. W. SULLIVAN, M.D.  
Meridian, Mississippi

SINCE DEATH due to pulmonary complications is extremely high in mucoviscidosis, early recognition is the most important contribution the radiologist can make toward salvaging the patient's life. Mucoviscidosis is a hereditary disease, occurring in 1:600 births, due to a generalized dysfunction of exocrine glands.

The chest x-ray, particularly in its earliest stages, is not diagnostic. Therefore, any persistent abnormal density should be considered as possible cystic fibrosis and correlated with clinical and laboratory studies. The early x-ray findings include air trapping, pneumonitis and atelectasis; the late findings are bronchiectasis, pulmonary fibrosis and cor pulmonale.

Air trapping (emphysema, a less descriptive term) is recognized by increased radiolucency of the lungs, flattening of the diaphragm (tenth rib posteriorly) and increased AP diameter of the chest. Fluoroscopy will show reduced air flow into the lungs. An entire lobe may collapse due to bronchial obstruction by viscid mucous prior to bronchial infection. Bilateral bronchopneumonia is variable in degree and extent. Bronchi, not seen in the normal lung, become visible due to thickening by inflammation or by peribronchial fibrosis, or if they are filled by mucus. Fibrosis is an outstanding feature in late stages. If an infection extends outside the bronchioles, focal consolidation occurs in patchy areas of various sizes. Although staphylococcus is the most common cause of

pneumonia in this disease, there is a staphylococcal paradox since pleural effusion does not occur as a rule.



*Figure 1. A 3-year-old white female is shown with early changes of mucoviscidosis.*

Sponsored by the Mississippi Radiological Society.





Figure 2. A 10-year-old white male is shown with moderate advanced changes of mucoviscidosis.

Enlarged lymph nodes, as well as vascular shadows, have been reported as contributing to the large hila. Radiating linear densities often predominate in the right subhilar area. Both pulmonary and bronchiectatic abscesses in great numbers cause fine and coarse stippling of the lungs. Some of the peribronchial abscesses rupture into the bronchial lumen and cause a cystic appearance when filled with air. Progression of the disease leads to pulmonary artery hypertension, cor pulmonale and death.

Diagnosis should be based on the presence of two of the following: (1) family history, (2) chest x-ray, (3) decreased enzymes and (4) repeated positive sweat tests (most consistent finding but not reliable on one examination and not valid before the infant is three months of age).

The differential diagnosis should include those conditions which produce obstructive emphysema; namely acute viral bronchiolitis, congenital deficiency of gamma globulin, asthmatic bronchitis, multiple abscess formation due to staphylococcus and fungus infection, miliary tuberculosis, aspiration of irritants, salicylate poisoning and the syndrome of Aldrich.

The early ventilatory difficulties usually respond well to local treatment (bronchial aspiration and in situ instillation of antibiotic and mucolytic agents) which is thought by some to be preferable to systemic antibiotherapy. ★★★

1418 22nd Avenue (39301)

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A psychiatrist is someone who doesn't have to worry as long as others do.

—Kansas Medical Journal



# The President Speaking

## “The Printed Word”

ARTHUR A. DERRICK, JR., M.D.

Durant, Mississippi

AT THIS POINT in time I realize that I may not possess the expertise to coordinate any guidelines for, or present any finalized format for a categorized methodology that would have any utilizable input or ongoing thrust into the feasibility of a regionalized delivery system of *plain old words*! Perhaps my backup profile of the norms and percentiles is coterminous with a resource bank that reflects an unmonitored lack of mobility or maldistribution, quite possibly paramedical in nature!

I find that now that I must wade through, literally, reams of the printed word, my attention is constantly being distracted by the innumerable neologisms with which these missiles are peppered. I still haven't quite forgiven the divines for revising the King James Version of the Bible, so you see I am conceivably a little biased on the subject.

I am no semanticist, but I truly believe Hayakawa would exclaim in horror, and probably in Japanese, at some of the mind-boggling gobbledygook contained in the supposedly informative material we get now from all quarters.

My plea is for a return to standard basic English. After all there are a few printable good old Anglo-Saxon four-letter words left! Let's use them! ★★★





## AMA Environmental, Occupational, and Public Health Council Issues Venereal Disease Statement

Gonorrhea ranks first (excluding influenza) and syphilis third among the reportable diseases in the United States. During 1972, there were 767,215 gonorrhea cases reported, 14.5 per cent higher nationally than the previous year and more than double the number reported in 1965. Increases have occurred in all parts of the nation and in all age and sex groups, but the largest concentration of cases is in the 15-24 year age group. Allowance for both under reporting and failure to diagnose all cases as they occur suggests that the actual occurrence of gonorrhea infection last year was about 2.5 million.

The Center for Disease Control estimates that the reservoir of gonorrhea includes 6 to 800,000 females and about 100,000 males who are asymptomatic. To help reduce this reservoir of silent carriers, most states have implemented gonorrhea screening programs for females. The Center for Disease Control reports that from July 1972 to March 1973 there were 3,117,022 females screened and 158,604 (5.1 per cent) had a positive test for gonorrhea. Of 664,110 females tested in private physician offices throughout the nation, 2.5 per cent had a positive culture for gonorrhea. The council urges medical societies to promote gonorrhea culture screening among females.

During 1972, syphilis morbidity (all stages) exceeded 91,000 reported cases. The number of congenital syphilitics under one year of age numbered 383 in 1972. Reported cases of primary and secondary syphilis (the infectious stages) numbered 24,429, up 3 per cent from the previ-

ous year, with an estimated 85,000 cases occurring annually. Because large numbers have escaped detection over the years, it is estimated that if every person in the United States could be tested for syphilis today, about 1/2 million previously untreated cases would be found.

An important procedure used to identify persons infected with syphilis or gonorrhea is laboratory reporting to public health authorities of those persons who have a positive test for either. The patient is contacted through his own physician for diagnosis and treatment if necessary. . . . Experience has shown that many laboratories refuse to report persons with a positive test for venereal disease to the health department until it is required by law or regulation. The council recommends that medical societies in these states not having such laws take appropriate action for the enactment of laws or regulations that require laboratories to report the positive venereal tests.

With the exception of Wisconsin, all the states now have laws or regulations permitting the treatment of minors for venereal disease without parental consent. It is believed, however, that some of the states' laws and regulations are so worded to make them inadequate. Also, some of the states might improve their laws by broadening the age group definition of minors.

Physicians in private practice treat approximately 80 per cent of the syphilis and gonorrhea that comes to diagnosis but report to public health departments only one out of every eight cases of syphilis and one out of every nine cases of gonorrhea.

rhca they treat. Physicians should assist public health departments by reporting the venereal disease cases they treat. Medical societies are urged to cooperate and give broad support to public health authorities. Much effort must still be made by health departments and medical societies to foster mutual trust so that public and private medicine can work effectively for the control of both syphilis and gonorrhea. Most state and some local health departments have venereal disease interviewer-investigators who can work confidentially with the patient and his contacts to determine the source and spread of his infection. The council urges the physician to utilize the services of these trained investigators.

Adequate therapy of venereal disease, using the right forms and dosages of antibiotics, is essential. *Neisseria gonococci* has shown the ability to develop resistance to penicillin to the point where the recommended dosage now is 4.8 million units of Aqueous procaine penicillin for the treatment of gonorrhea in both males and females. It is anticipated that additional changes in treatment may have to be made from time to time as increasing resistance becomes a problem or more effective antibiotics are discovered. For this reason the council urges that medical societies impress upon their members the need for keeping abreast of changes in the recommended therapy of the venereal diseases.

The council encourages the publication of more articles in professional journals on venereal disease and its control for the guidance of the profession. Medical societies are asked to support education of parents and the public through more extensive and imaginative use of all available media and through school curriculum.

The council urges medical societies to acquaint their membership with the growing and alarming dimensions of the venereal disease problem. Physicians should take all appropriate measures to reverse the rise in venereal disease and bring it under control.

535 N. Dearborn St.  
Chicago, Ill. 60610

## Mississippi Makes Plans for the Bicentennial

On July 4, 1776, the Continental Congress adopted the Declaration of Independence proclaiming that "the United Colonies are, and of a Right ought to be, Free and Independent States."

Ever since that fateful July day, Americans have celebrated Independence Day as the official birthday of the United States of America. As a people, we are fast approaching our two hundredth birthday—the Bicentennial Observance of our Independence. Preparations for that observance began in 1966 when Congress established the American Revolution Bicentennial Commission. Dedicated to the theme "A Past to Honor: A Future to Mold," the National Bicentennial Commission has been striving to make the two hundredth anniversary of our country a meaningful and lasting national experience. President Richard M. Nixon in his charge to the commission captures well this Spirit of 1976: "America is 50 states. America is big cities, small cities and small towns. It is all the homes and all the hopes of 208 million people. That is why we want this celebration to be national. It must go directly to the people and derive its strength from the people."

In keeping with the President's charge, the American Revolution Bicentennial Commission has decided that the Bicentennial Observance should be much more than a one-day celebration and should not be limited in scope to commemorating the revolution alone. It should be a relevant commemoration of our heritage. Activities for 1976 will be designed to enable the citizenry to reflect upon America's heritage, place it in historical perspective, and provide goals and direction for our future as a nation. Certain themes



"FREDDY HOPES TO BECOME A DOCTOR."



and guidelines have been provided by the officials in Washington, D. C., but it is up to the state commissions to plan, implement and coordinate programs within the respective states.

That is why the Mississippi Legislature in 1972 created the Mississippi American Revolution Bicentennial Commission. Chaired by the Honorable James P. Coleman of the United States Court of Appeals, Fifth Judicial Circuit, it is the duty of this commission "to assist the American Revolution Bicentennial Commission in preparing and executing activities relating to the celebration of the second century of our nation's independence."

On the state level the Mississippi commission has undertaken the following projects:

1. Restoration of Jefferson College, birthplace of Mississippi's statehood, as a museum for south-west Mississippi.

2. Publication of the *History of Mississippi* under the editorship of Dr. R. A. McLemore, Director of the Mississippi Department of Archives and History.

3. Participation in the Franklin Mint-sponsored medal contest which has recently been completed.

4. Publication of a special issue of the *Journal of Mississippi History* in February, 1975, dedicated to Mississippi during the colonial and revolutionary periods.

5. Publication of a brochure to be entitled "Mississippi During the American Revolution" to be made available to our school-age youth.

6. Designation of Sunday, July 4, 1976, as "A Special Day of Worship and Thanksgiving."

7. Co-sponsorship of "Mississippi's Bicentennial Folk Voices," an annual series of concerts to be held at the Old Capitol Museum featuring Mississippi musicians who possess unique musical skills and styles. (Every effort is being made to have these concerts televised by Educational Television so that all Mississippians can enjoy them.)

8. Publication of a work on "Mississippiana" which shall be composed of materials on Mississippi's past researched and written by our young people.

9. Participation in the Library of Congress' "Liberty and Learning" project, the purpose of which is the locating and processing of original source material (written or printed) in Mississippi which relates to the era of the American Revolution.

10. Publication of *Historic Mississippi: Mississippi's Entries on the National Register of Historic Places*.

11. Sponsorship of an exhibit, "The Main Campaign," which examines the history of Presidential elections through the memorabilia which have survived. To be held in 1974 at the Old

Capitol Museum, this exhibit has been secured with the assistance of the Pennsylvania American Revolution Bicentennial Commission. (Every effort is being made to have this exhibit televised by Educational Television so that all our people might be able to benefit from it.)

In addition to the above, the Mississippi American Revolution Bicentennial Commission is considering publishing and/or microfilming British and Spanish documents which relate to the colonial and revolutionary periods. Also, the commission has endorsed the establishment of Fort Maurepas Historic Site and the development of Jacinto Court House.

As important as these projects might seem, the real celebration of our Independence will be in the hearts and minds of our people. For this bicentennial to have a lasting impact on the history of our nation, people are going to have to ask themselves: "What can I do to improve life where I live? What can I do to help others and in the process help realize the ideas and the ideals for which men lived and died some two centuries ago?" The bicentennial offers an unparalleled opportunity for all Mississippians to come together in the spirit of trust, dedication and cooperation to reflect on who they are and where they want to go.

Believing strongly that the Bicentennial Celebration must derive its strength from the "grass roots," from the people in Mississippi's communities, the Mississippi American Revolution Bicentennial Commission has authorized a *Community Bicentennial Guide* and a *Bicentennial Newsletter* to assist community leaders as they participate together in Community Bicentennial Committees. The *Guide* is something of a manual of operations for the local committees. The purpose of the *Newsletter* is to inform Mississippians of the bicentennial and to coordinate bicentennial planning throughout the state.

The commission believes that the thrust of the Bicentennial Celebration, as opposed to earlier celebrations in American History, should be indeed the "Honoring of Our Past" and "Molding of Our Future." Rather than sponsoring the growing of beards, each community is being challenged to use the bicentennial as a vehicle to accomplish meaningful objectives and bring about constructive change. These objectives will vary from community to community. For one community it might involve urban beautification; for another improving recreational facilities for the young and old; for another preserving or restoring historic buildings; and for yet another developing its aesthetic resources.

## EDITORIALS / Continued

With the interest and support of all Mississippians, the Bicentennial Celebration can contribute mightily to making our third century of freedom still greater than the century which shall end July 4, 1976.

PERRY A. SNYDER, Director  
Mississippi American Revolution  
Bicentennial Commission



### NEW MEMBERS

BANKS, FRANK R., Jackson. Born Jasper, Ala., Sept. 20, 1936; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1961; interned Letterman General Hospital, San Francisco, Calif., one year; Ob-Gyn residency, University of Missouri, Columbia, Mo., 1965-68; elected by Central Medical Society.

ELLIS, BERNARD HOPKINS, Columbus. Born Columbus, Miss., Jan. 11, 1925; M.D., University of Tennessee School of Medicine, 1954; interned Methodist Hospital, Memphis, Tenn., one year; psychiatry residency, Rullman Psychiatric Institute, Cincinnati, Ohio, 1969-71; elected by Prairie Medical Society.

HOWELL, HENRY FRANK, II, Jackson. Born Jackson, Miss., Jan. 27, 1946; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1971; interned Mississippi Baptist Hospital, Jackson, Miss., one year; elected by Central Medical Society.

JABALEY, MICHAEL ELLIS, Jackson. Born Cooperhill, Tenn., July 12, 1934; M.D., Johns Hopkins, Baltimore, Md., 1961; interned, same, one year; surgery residency, Massachusetts General Hospital, Boston, Mass., 1962-66; plastic surgery residency, Johns Hopkins, Baltimore, Md., 1966-68; elected by Central Medical Society.

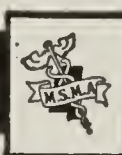
POLK, JAMES DAVID, Jackson. Born Auburn, Ala., April 5, 1945; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1971; interned Mississippi Baptist Hospital, Jackson, Miss., one year; elected by Central Medical Society.

RAWSON, JOHN E., Jackson. Born Okolona, Miss., Jan. 31, 1938; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1965; interned Vanderbilt University Hospital, Nashville,

Tenn., one year; pediatric residency, same, 1966-67; pediatric residency, University Medical Center, Jackson, Miss., 1967-68 and 1970-72; elected by Central Medical Society.

TRUETT, GEORGE WESLEY, Jackson. Born Jackson, Tenn., May 1; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1961; interned, same, one year; orthopaedic surgery residency, same, 1968-72; elected by Central Medical Society.

YAWN, VICTOR WADE, JR., Jackson. Born McComb, Miss., Oct. 22, 1946; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1971; interned, same, one year; elected by Central Medical Society.



### DEATHS

BURNETT, RILEY WILSON, Biloxi, M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1915; died July 14, 1971, age 82.

## Breast Cancer: earlier warning system

Futility and frustration beset the physician confronted with breast cancer. For the last 35 years, the survival rate has not significantly changed despite intensive educational programs aimed at earlier detection, and improvement in treatment techniques.

What is the outlook? We know the key to reducing mortality from breast cancer is in the earliest possible diagnosis. The stage at which breast cancer is detected is crucial to the outcome of treatment. By the time a lump is discovered through BSE or clinical examination, critical time may have been lost.

And we do have the means to achieve earlier diagnosis. We do have an earlier warning system. Mammography and thermography can detect breast cancer before a lump is discernible by palpation. To demonstrate that it is practical and feasible to detect breast cancer earlier by using these modalities, the American Cancer Society and the National Cancer Institute are funding a network of breast cancer

demonstration projects. Supported by grants of \$2-million from the ACS and \$4-million from the NCI, 20 such centers are expected to be operative across the country by the end of the year. Each will screen at no charge, approximately 5,000

women annually, in what is considered to be the ideal detection program—to include clinical examination, mammography and thermography. Each of these detection methods contributes independently to the detection of breast cancer, and none can be dispensed with in the search for early disease.

At present we cannot prevent breast cancer, but the potential for saving more lives is immense. The five-year survival rate changes dramatically from 53% when axillary nodes are positive, to 85% when the disease is localized, to nearly 100% for in-situ cancer.

We have an earlier warning system. Let's use it.



american cancer society





### Book Review

**Surgery in World War II—Orthopaedic Surgery in the Zone of Interior.** By Mather Cleveland, M.D., and Alfred R. Shands, Jr., M.D., Editors for Orthopaedic Surgery: 1099 pages. Washington, D. C.: Office of the Surgeon General, Department of the Army, 1970. \$12.25.

This is a historical compilation by an impressive array of authors and contributors. It is presented with frankness and candor but 1099 pages to be searched for a few pearls of practical information which can be found in concise form in other sources is too much. Emphasis is placed on many conditions which seem trivial or merely inconvenient in civilian life but also are found to produce significant manpower loss in civilian workmen. Such conditions are carpal scaphoid fractures, march fractures and complaints referable to the feet, back and knees.

The importance of rehabilitation programs from early treatment to return to function is recognized and an appeal is made for physicians to be cognizant of the importance of rehabilitation.

Chapter XXVIII on "Injuries and Lesions of the Spine and Low Back" contains a brief, informative discussion of "The Low Back Syndrome" which any physician could profitably read.

This book is one for a reference library, primarily of historical interest.

GEORGE D. PURVIS, M.D.  
Jackson, Miss.

### Cardiovascular Seminar Set for London

Symposia Medica Foundation, in cooperation with The Royal Society of Medicine, presents an international seminar on cardiovascular disease to be held in London, Oct. 12-20, 1973.

The chairman is Professor John P. Shillingford, president, British Cardiac Society.

The registration fee is \$100.00.

For further information, contact: Cynthia Soika, M.A., Projects Director, Symposia Medica Foundation, 305 East 24th Street, Suite 17-F, New York, N.Y. 10010.

### Pediatric Pulmonary Course Set

The Third Annual Pediatric Pulmonary Course will be held Jan. 22-24, 1974, at Louisiana State University Medical Center in New Orleans and will have as its theme "Pediatric Respiratory Intensive Care."

The course is sponsored by the Louisiana Thoracic Society, the medical section of the American Lung Association of Louisiana, Inc., formerly known as the Louisiana TB and Respiratory Disease Association.

Designed as mostly a clinical course, the postgraduate level session is open to all pediatric specialists. The participants will take part in lectures and follow up the lectures with practical workshops that will allow them to gain valuable first-hand experience from experts in various fields of pediatric respiratory intensive care.

Planning Committee Chairman, Dr. Judith A. Harris of New Orleans announced that the guest faculty for the course will include Drs. Robert Winters, Professor, Department of Pediatrics, Columbia University, New York; John J. Downes, Children's Hospital, Philadelphia; and Victor Chernick, Children's Hospital, Winnipeg, Manitoba, Canada.

This course is also sponsored by the American Thoracic Society; The American Academy of Chest Physicians; National Cystic Fibrosis Research Foundation; Alton Ochsner Medical Foundation; Louisiana State University, School of Medicine, Medical Center, both in New Orleans and Shreveport; and Tulane University School of Medicine. The Louisiana Thoracic Society is accredited by the American Medical Association as a continuing education course.

All guest faculty members will take part in a case presentation session and a symposium titled Supportive Care for Ventilator Patients.

Tuition for the course is \$90.00, and members of ATS may register for \$75.00. Additional information may be obtained by writing W. Findley Raymond, Executive Director, ALA of La., Inc., 333 St. Charles Ave., Suite 1504, New Orleans, La. 70130.



## LETTERS

SIRS: On June 14, 1973, a nine-month-old child was brought to a maternity clinic at the Harrison County Health Department by her pregnant mother. Thirty-two other pregnant women who were predominately in their first and second trimesters were in contact with this child in the waiting room for approximately two hours. A number of women held and played with the child during this time.

When the child was seen by the clinic physician, a presumptive diagnosis of rubella was made on the basis of a typical rash, posterior cervical lymphadenopathy, no prior immunization against rubella, and contact with a neighborhood child who was thought to have had rubella recently. Blood was drawn for hemagglutination inhibition (HI) titers on all women exposed at the clinic. In addition, acute and convalescent sera were obtained from the affected child. Fortunately, the child's acute and convalescent HI titers were both less than 1:8, and a diagnosis of rubella was effectively ruled out. HI titers done on the 33 pregnant women disclosed that 23 (39.6 per cent) were seroimmune (i.e. had HI titers of 1:8 or greater) and 10 (30.4 per cent) were susceptible to rubella (i.e. had HI titers of less than 1:8) exposed women. (This case was reported by Dr. L. H. Jobe, Jr., director, Harrison County Health Department; Mrs. Marlyn Hatten, Public Health Laboratory, MSBH; Mr. Richard H. Andrews, director, Public Health Laboratory, MSBH, and Mr. Paul Turner, supervisor, Immunization Program, MSBH.)

This investigation emphasizes several points. The diagnosis of rubella is frequently difficult and in instances where pregnant females are exposed to an individual with a rubella-like illness, HI titers obtained from the source of exposure can be very helpful. In addition, an appreciable number of women of childbearing age may be susceptible to rubella. A rubella serologic survey of adolescents, age 13 to 18 years old, done in DeKalb County, Ga., in 1971 showed that 76.6 per cent of 1,004 unvaccinated students were immune. Immunity levels were highest in an urban school (82.1 per cent) and lowest in a suburban school (67.3 per cent).<sup>1</sup> This study also showed, as others have shown,<sup>3</sup> that a history of previous rubella is an unreliable index of immunity. In another study done in Tampa, Fla., 81 per cent of

young adults, 20-29 years old, were seroimmune.<sup>2</sup> Our division does *not* recommend gamma globulin in instances of suspected rubella exposure of a pregnant female—since it has not been shown to be effective in preventing viremia or clinical illness<sup>3</sup> and it may confuse the serologic diagnosis in a potentially infected pregnant woman. In addition, both the physician and the patient may acquire a dangerous and false sense of security after gamma globulin administration.

DURWARD BLAKEY, M.D., Director  
Division of Preventable Disease Control  
Mississippi State Board of Health

## REFERENCES

1. WYALE, S. A. and Grand, M. G.: Rubella in Adolescents: Serologic Assessment of Immunity Levels. *JAMA* 220:1573-1575, 1972.
2. Witte, J. J., Karchmer, A. W. and Case, G. et al: Epidemiology of Rubella. *Am. J. Dis. Child.* 118:107-111, 1969.
3. Green, R. H., Balsamo, M. R., Giles, J. P., Krugman, S. and Mirick, G. S.: Studies on the Natural History and Prevention of Rubella. *Am. J. Dis. Child.* 110:348-365, 1965.

SIRS: Aseptic meningitis is defined as a clinical syndrome of various etiologies consisting of signs of meningeal irritation which are usually accompanied by cerebrospinal fluid pleocytosis and a short uncomplicated course. Outbreaks characteristically occur in the summer and autumn. In this country, the syndrome is most commonly caused by enteroviruses although in a large number of cases an exact etiology is not determined. Other known etiologies include arboviruses (SLE, CE, WEE, VEE, EEE), mumps (which usually occurs in the winter and early spring), herpes simplex, adenoviruses, lymphocytic choriomeningitis, and mononucleosis.<sup>2, 3</sup> In 1971, 4,073 cases of aseptic meningitis with 30 deaths were reported to the Center for Disease Control (CDC) from 44 selected reporting centers. A diagnostic etiology was found for 739 cases. Of these, 611 were associated with enteroviruses, 90 with mumps, 12 with herpes simplex, 2 with western equine encephalomyelitis (WEE), and 2 with St. Louis encephalitis (SLE), and 16 with other agents.<sup>1</sup>

Eighty-seven cases of aseptic meningitis were reported to our division in 1971 and 1972. Reporting is known to be inconsistent in different regions of the state and an unknown number of cases go unreported. Over half (51 per cent) of all reported cases were from Hinds and Harrison counties. Two deaths were attributed to aseptic meningitis: one in a 99-year-old female from Rankin County and another in a 78-year-old female from Lincoln County. In three instances



more than one case occurred in the same family. More cases occurred in males (61 per cent) than in females, and in whites (87 per cent). An etiologic diagnosis was found in only four cases (4.6 per cent). In 1971, two isolates of Echovirus Type-4 were made in young adolescents from Harrison and Sunflower counties. In 1972, an Echovirus Type-9 isolate was made from the stool of a five-month-old boy who had a clinical illness typical of aseptic meningitis. A fourth case was attributed to infectious mononucleosis. The peak number of cases were reported in the summer and early fall months. This is consistent with national trends and is probably due to the seasonal pattern typical of enteroviruses.

Mississippi physicians can expect to see cases of aseptic meningitis this summer and fall and are able to obtain free viral studies through the Mississippi Public Health Laboratory. Specimens for viral isolation attempts should be collected in the earliest days of illness and should be frozen as soon as possible after collection. Stool (or rectal swab), throat swabs or washings, and spinal fluid are recommended for attempts to isolate enteroviruses. Acute and convalescent sera should also be obtained. The appropriate local health department should be notified so that special containers containing dry ice can be made available for transport of specimens to Jackson. Because of the large number of Coxsackie and Echo virus types, it is not practical for serologic specimens to be tested *unless* an enterovirus has been isolated from the patient. If an isolate is made, acute and convalescent sera are tested for antibody to that particular virus type. If a 4-fold titer rise occurs, laboratory documentation of infection with that virus is assumed. Because of the small number of arbovirus types, it is possible to test paired sera for the presence of rising titers without an antecedent viral isolate, the same is true for cases of aseptic meningitis thought to be due to mumps. For consultation concerning cases of aseptic meningitis or other suspected viral illnesses, please call our division at 354-6650.

DANIEL J. SEXTON, M.D.  
Division of Preventable Disease Control  
Mississippi State Board of Health

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1. Aseptic Meningitis. Annual Summary—1971. Center for Disease Control, issued May, 1973.
2. Adair, C. V., Gauld, R. L. and Smadel, J. C.: Aseptic Meningitis, a Disease of Diverse Etiology: Clinical and Etiologic Studies on 854 Cases. *Ann. Intern. Med.* 39:675-704, 1953.
3. Wenner, H. A.: The Enteroviruses. *Am. J. Clin. Path.* 57:751-761, 1972.



## PERSONALS

S. MARK ALLEN has joined the staff of the Watkins-Carter Clinic in Quitman for the family practice of medicine.

RICHARD P. BISHOP and M. ROBERT HILL have joined the West Colbert Clinic in Cherokee.

DONALD J. BOOTH has associated with the Bolton-Middleton Clinic in Biloxi for the practice of surgery.

GUY R. BRASWELL and MIKE C. CAMPBELL announce their association for the practice of ophthalmology in their new offices at 990 J. K. Avent Drive in Grenada.

JOHN BROOKS has joined the Gamble Brothers and Archer Clinic in Greenville.

PAT S. BURKE has associated with ROBERT RAY MCGEE and WALTER T. TAYLOR for the practice of internal medicine at the Medical Arts Building in Clarksdale.

BYENG S. CHOO, formerly of Natchez, has joined the staff of the Medgar Evers Comprehensive Health Clinic in Fayette.

R. M. COOK, a native of Hattiesburg and formerly of Sumrall, has set up practice in Lumberton.

QUINTON H. DICKERSON, JR., announces his association with WILLIAM H. ROSENBLATT, JAMES C. HAYS and JAMES L. CROSTHWAIT at the Jackson Heart Clinic, 615 Medical Arts Building, Jackson.

H. B. HEITZMAN announces the opening of his office for the practice of internal medicine at the Coastal Medical Center, P.A., Gateway Executive Park in Biloxi.

L. G. HOPKINS, JR., and JAMES MANN of Oxford were presented plaques at the Annual Chamber of Commerce Banquet in Oxford for their work in securing the mental retardation hospital.

JAMES R. HOUSE, JR., has associated with FRED D. HILL, JOHN A. MCLEOD, III, JOSEPH B. McMILLON, and KATHERINE S. ALDRIDGE of Hattiesburg for the practice of anesthesiology at Suite 102, Medical Plaza Building, 2601 Mamie Street.

MICHAEL E. JABALEY of Jackson and UMC has been named to the Plastic Surgery Research Council at the annual meeting in St. Louis. Membership is limited to those who are involved in plastic surgery basic research.

## PERSONALS / Continued

WALTER R. JONES, JR., has associated with J. P. CULPEPPER, III, and JOE E. VARNER, JR., for the practice of general surgery. Their offices are located in the Medical Plaza Building, Suite 105, 2601 Mamie Street in Hattiesburg.

BOYD KELLETT has associated with the Sigrest-Thompson Clinic at Fifteenth Street in Yazoo City. Dr. Kellett is a graduate of McGill University in Montreal.

LEDON LANGSTON has associated with JOHN N. HARRINGTON and PERRIN N. SMITH for the practice of obstetrics and gynecology at the Medical Arts Center, 221 North 7th Street in Columbus.

JOHN P. LEE announces the opening of his medical practice at 285 East First Street in Forest.

HENRY A. MAGGIO announces the opening of his office for the practice of psychiatry at 4500 West Pass Road in Gulfport.

G. S. MCHENRY and H. F. CAMPBELL received a plaque from the Pine Burr Area Council of the Boy Scouts of America for their long years of faithful service.

MARTIN H. MCMULLEN has associated with JAMES C. HARVEY, JR., J. HARVEY JOHNSTON, JR., THOMAS L. KILGORE, JR., and W. COUPERY SHANDS for the practice of cardiovascular surgery at 710 North State Street in Jackson.

JAMES RONALD MEDLIN announces his association with JAMES W. SPECK in the practice of medicine at the Ecu Clinic, Ecu, Miss.

C. DOUGLAS ODOM has associated with CLAUDE G. CALLENDER, JAMES L. ROYALS, C. G. SUTHERLAND and O. B. WOOLEY, JR., for the practice of obstetrics and gynecology at the Women's Clinic, 918 North State Street in Jackson.

WILLIAM ELLIS O'MARA has associated with JAMES MAYFIELD of Carthage to practice medicine at 600 Highway 16 West. Dr. O'Mara is a graduate of the Tulane Medical School.

HARRELL S. PACE announces the opening of his offices for the practice of otolaryngology and maxillofacial surgery at the Coastal Medical Center, P.A., Gateway Executive Park in Biloxi.

CHARLES RAY SECREST announces the opening of his office in the Doctor's Park Clinic at Houston for the practice of internal medicine.

J. TATE THIGPEN has joined the faculty of the University Medical Center at Jackson in the Di-

vision of Hematology-Oncology of the Department of Medicine.

B. G. TROSCLAIR announces the relocation of his office to Morgantown Clinic in Natchez. Dr. Trosclair will be associated with JOE D. HERRINGTON in the family practice of medicine.

## Ophthalmology Meeting Scheduled

The American Society of Contemporary Ophthalmology announces its 1974 annual meeting, Feb. 10-16, 1974, at the Fontainebleau Hotel in Miami Beach.

Continuing education courses in all areas of ophthalmology, accredited by the AMA, will be offered. Microsurgery of the eye; lectures and small group discussions in cataract, glaucoma, diseases of the retina and cornea, strabismus, plastic surgery, soft lens, angiography and other important topics, will be given.

For further information write to Miss Virginia Kendall, ASCO, 30 N. Michigan Avenue, Room 1506, Chicago, Ill. 60602.

## CHAMPUS Beneficiaries Identify Themselves

CHAMPUS beneficiaries who use civilian hospitals can assure themselves of maximum savings and program benefits by notifying hospital officials on admission that they are entitled to the benefits of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Under the provisions of the military medical care program retirees and their authorized dependents are responsible for only 25 per cent of the health care bill when they are hospitalized. Authorized dependents of active duty uniformed service personnel pay \$1.75 per day with a minimum charge of \$25 for inpatient civilian hospital care.

Although CHAMPUS Hospital Contractors in each state are continually briefing civilian facilities on program details, a recent study has shown that beneficiaries should remind admissions clerks and hospital billing offices of their CHAMPUS eligibility.

Questions on payment procedures by inpatient facilities should be referred by the beneficiary to the state hospital contractor.





# Council on Scientific Assembly Announces Format for the 106th Annual Session

Preliminary plans and schedules for the 106th Annual Session set for Biloxi, May 6-9, 1974, were made in a Council on Scientific Assembly

meeting held at the Sheraton-Biloxi Hotel in late July. This was the announcement of Dr. James P. Spell of Jackson, chairman of the council.

On the annual session meeting agenda are the House of Delegates and reference committees for Monday with the final meeting of the policy-making body scheduled for Thursday afternoon.



*Dr. Spell*

The seven scientific sessions will again offer top guest essayists with a new emphasis on in-state participation in 1974. On Tuesday, May 7, the morning will feature the section on surgery. That afternoon the section on ob-gyn will meet. On Wednesday, May 8, the morning session will present the section on medicine. The afternoon offers programs by the section on general practice and section on preventive medicine. On Thursday morning, May 9, the section on pediatrics and section on EENT will meet simultaneously. Correlated film showings will also be offered.

Dr. Spell said that as many as 15 specialty societies and related groups will meet concurrently with the annual session, usually selecting a day adjunctive to general scientific meetings con-

cerned with the particular specialty. Of further interest will be specialty society luncheons and dinner occasions.

The Woman's Auxiliary will meet concurrently with the MSMA annual session for its 51st annual session. Mrs. W. H. Preston, Jr., of Booneville is president.

Dr. Spell said the medical alumni groups representing Ole Miss, Tulane, Tennessee and Vanderbilt are scheduling social occasions. Ole Miss will meet on Monday, May 6, both in a business session and for an evening dinner and dance party. Tulane, Vanderbilt and Tennessee medical alumni will meet on Tuesday, May 7, Dr. Spell said.

Special events will include the Fifty Year Club luncheon, Past President's breakfast, and the annual association fellowship party. The council voted to abolish the annual association golf tournament on the basis of poor participation and the recommendation of last year's chairman.

Delegates will meet on Monday to receive reports and resolutions which will be discussed before reference committees that afternoon. Dr. Arthur A. Derrick of Durant, MSMA president, will open the convention. The Nominating Committee will conduct open sessions on Wednesday, and on Thursday, the House will take final actions on business and policy, electing 1974-75 officers as the final order of business.

Dr. J. T. Davis of Corinth, president-elect, will be inaugurated 1974 president at the adjourned meeting of the House of Delegates, and new officers will assume their respective posts at that time.

Technical and scientific exhibits will also be featured during the four-day annual session.

## St. Dominic's Makes Dedication Plans

St. Dominic's Dedication Day is Sept. 16.

The newly-elected chairman of the Board of Governors of the Mississippi Hospital Association, William K. Ray of Clarksdale, will give the main address at the public ceremony on the hospital's front lawn at 2 p.m.

Dignitaries invited to speak are Dr. A. A. Derrick, Jr., of Durant, president of the Mississippi State Medical Association; Dr. Alton Cobb, state health officer; and John Caldwell, Jr., chairman of the hospital's advisory board.

St. Dominic's chief of staff, Dr. William B. Thompson, will extend a welcome and invite guests to tour the new facilities. Mother Jeremiah, mother general of the Springfield, Ill. community of Dominican Sisters who run St. Dominic's, will respond.

A personal guide for each group of about 15 visitors will conduct tours about the new facility following the outdoor ceremony. Each department will provide hosts who can explain services.

Dedication day is for the general public, and the specific health care communities have their own turn earlier.

St. Dominic's medical staff and their spouses had a preview of the completed facilities on Aug. 25, when they were invited to a buffet dinner and tour.

The Jackson-Vicksburg Hospital Council is invited to lunch on Sept. 13, with a tour to follow.



*The old Jackson Infirmary when the Sisters of St. Dominic came to Jackson in 1946.*

A special mass for the Catholic community and guests is set the same day as the civic ceremony, starting at 11 a.m. in the hospital chapel. Bishop Joseph B. Brunini will celebrate mass, assisted by

Msgr. Bernard Law and the Rev. Anthony Pudenz, hospital chaplain. Because the hospital chapel capacity is so limited invitations will be issued for the religious ceremony.

St. Dominic's broke ground for a new south wing addition to the hospital on June 26, 1969. Before it was finished, the expansion got a lot more involved than just adding hospital beds.

Service areas had to be expanded to take care of the additional patients. A new laundry was built, a new cafeteria, a data processing room with a new Century computer, admissions and medical records are twice as big as they had been, a new central processing section, and enlarged everything from pharmacy to the business office.



*The first St. Dominic's Hospital on Lakeland Drive opened in 1954.*

Then there came to the Sisters' attention the need for a community comprehensive mental health center, with time running out to apply for a federal grant to build it. The Sisters agreed to take the responsibility and put up the matching money.

The next identified community need responded to was a medical offices building and parking garage adjacent to the hospital, a convenience to doctors and benefit to patients.

The Jackson Mental Health Center was the first finished phase of the expansion program. Dedication was in May, 1971.

A year later, on April 29, 1972, the entire hospital did a complete about-face. A main entrance moved from north to south, from facing Lakeland Drive to facing downtown Jackson.

Patients were moved from the north wing, built in 1954, to the south wing where everything is brand new—from the electrically-controlled beds to the wall-mounted tv sets, and from the





*St. Dominic-Jackson Health Services viewed from I-55, showing the main entrance on the south.*

nurse patient intercom to the self-dialing princess phones.

In December the first staff doctors moved into their new suites in the medical office building. Meanwhile the north wing of the hospital was empty except for the contractors who were doing the face-lifting which took well over a year from the time the wing was vacated.

Moving back in the summer of '73 proved a lot harder than getting settled on the south side. The north wing move had to be done in stages. It's easier to build from scratch and fully furnish with brand new everything, the St. Dominic's family learned, than to work around what's there.

To complicate matters, while the first move left the hospital the same size it had been—with the same requirements for personnel and service facilities—occupying the north wing doubled everything. So it took time; e.g., who can double the size of a nursing staff simply by needing more nurses?

That it is now accomplished is cause for the celebration on Sept. 16, in the opinion of Sister Josephine Therese, administrator, and her Dominican colleagues.

The construction has sorely tried their patience, if not their patients. Living with the muddle and disorder of remodeling is enough to make a nun irascible.

But a bigger and better community service was worth the inconvenience and worth the waiting. Now that it's over, that's how they feel.

What came of it all was—

—The largest private hospital in the state, providing the community with 409 beds for medical, surgical, pediatric, and psychiatric patients.

—Such new radiology services as a Franklin head unit, tomographic unit, panoramic machine, special procedures room with sophisticated angiography equipment and facilities for cardiac catheterization on order, pho gamma scintillation cameras,

—New operating suites with Allander air curtain equipment in two rooms for total joint replacements now being done and open heart surgery equipment on order,

—Materials management system including total automated delivery system via self-propelled carts.

—Intensive and coronary care with telemetry monitoring for intermediate patients,

—Respiratory therapy and special diagnostic services with electroencephalogram lab, vectorcardiography and echocardiography,

—Full-time physician coverage in the emergency room,

—Pharmacy unit dose and admixture systems,

—All-new physical therapy department with latest equipment,

—and everything else arranged for the best possible health care, St. Dominic's only reason for existence.

The best possible health care is a continuing process of improving, as Sister Josephine Therese sees it, and of responding to needs. For example, even before completion of the job, right after the obstetrical section was completed with just what

the doctors ordered in delivery and labor and nurseries, it became sadly obvious that changes would have to be made. The problem: not enough deliveries, which kept scarce nursing service personnel on ready waiting for baby business that never came.

So the brand new obstetrical service was closed in early August, the beds assigned to other sections and the precious nurses back to being busy with patients. Still more remodeling will be necessary to convert labor, delivery, and nurseries to other uses.

Still more new equipment needed to extend and improve existing programs in health care is on order—a hemodialysis unit, cardiac catheterization equipment, the cardiopulmonary pump for open heart surgery.

## Mississippi EMCRO Is Refunded

The Mississippi State Medical Association EMCRO project has been refunded for two additional years. EMCRO funding was approved for a two year period beginning June 1, 1973, at \$288,456 the first year and \$248,000 the second year.

Major EMCRO activities for 1973-1974 will be to continue development and expansion of a system of concurrent and retrospective review of hospital inpatient care and retrospective review of hospital emergency room care. EMCRO will also begin development of a system of continuing medical education and a system of concurrent and retrospective care review of nursing home services.

Recently, the MSMA/EMCRO enrolled the 50th participating hospital in its retrospective care review system. In the next few months EMCRO will be making an effort to expand this system to every hospital in the state.

The EMCRO will continue its concurrent care review and length of stay monitoring project at the Tyler Holmes Memorial Hospital in Winona. This system will be tested under new funding of the EMCRO which will involve expansion of the system to three hospitals throughout the medical trade area around Winona and also expansion to one and possibly two other hospitals outside the trade area.

# Rondomycin<sup>®</sup> (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** **Gastrointestinal** (oral and parenteral forms) anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** 'Rondomycin' (methacycline HCl). 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



WALLACE PHARMACEUTICALS  
CRANBURY, NEW JERSEY 08512



# Medico-Legal Briefs

## CITY HOSPITAL MAY NOT BAN STERILIZATIONS

A city hospital may not constitutionally bar the use of its facilities for tubal ligations, a federal appellate court ruled. The court ruled that the recent United States Supreme Court decisions on abortion prohibited such a complete ban.

A 36-year-old woman had had 12 pregnancies, resulting in eight live children. Her high blood pressure and umbilical hernia rendered future pregnancies a threat to her life. Her blood pressure and heavy and irregular menstrual flow rendered other contraceptive measures either dangerous or ineffective. The woman's physician recommended a therapeutic sterilization.

The municipal hospital was established to accept persons requiring short-term relief. The woman and her husband had a combined income below the federally defined poverty level for a non-farm family of 10. The municipal hospital would admit her for the performance of any permitted inpatient procedure. The hospital's facilities were used for such procedures as appendectomies, hemorrhoidectomies, rhinoplasties and skin grafts. Its Board was empowered to establish rules and regulations not inconsistent with law.

The state assistant solicitor issued an opinion that, in light of the state's birth control statutes, the legality of sterilization operations was highly doubtful. Based on this opinion, the hospital barred the use of its facilities for any consensual sterilization.

When the hospital refused to allow its facilities to be used for a sterilization procedure, the woman filed suit. The trial court dismissed her complaint and she appealed.

Reversing the trial court's ruling, the federal appellate court ordered the hospital not to enforce its policy of denying the use of its facilities for sterilization procedures. The recent United States Supreme Court abortion decisions prohibit a complete ban on such surgical procedures.

The court noted that the hospital may establish policies commensurate with its budget, facilities, and abilities of its staff. However, it also noted that the hospital permits the use of its facilities for procedures, including non-therapeutic elective procedures, involving no greater risk than tubal ligations. Therefore, the court ruled that a hospital providing general short-term care may not constitutionally prohibit medically indistinguishable procedures which involve fundamental rights such as those relating to pregnancy decisions.

The hospital is not required to perform all therapeutic or non-therapeutic procedures or to maintain its present facilities and staff, the court noted. The city is not even required to maintain the hospital, the court added. The court ruled only that the hospital may not impose a complete ban on sterilization procedures.—*Hathaway v. Worcester City Hospital*, Docket No. 72-1114 (C.A. 1, March 22, 1973).

## Tom Buntyn Joins EMCRO Staff

Mr. Tom Buntyn has joined the staff of the Mississippi EMCRO program as systems analyst, according to Mr. Charles L. Mathews, MSMA Executive Secretary.

Mr. Buntyn is a native Mississippian and a graduate of Mississippi State University. He has done graduate work in applied mathematics at Auburn University and earned the M.A. degree in mathematics from the University of Alabama at Huntsville.

He has 12 years of computer related experience as a systems analyst and in design of informational and analytical systems.

Mr. Buntyn has previously worked with Douglas Aircraft Co., the U. S. Navy, Brown Engineering Company's Aerospace Programs, Mississippi State Department of Public Welfare and the Mississippi Medicaid Commission.

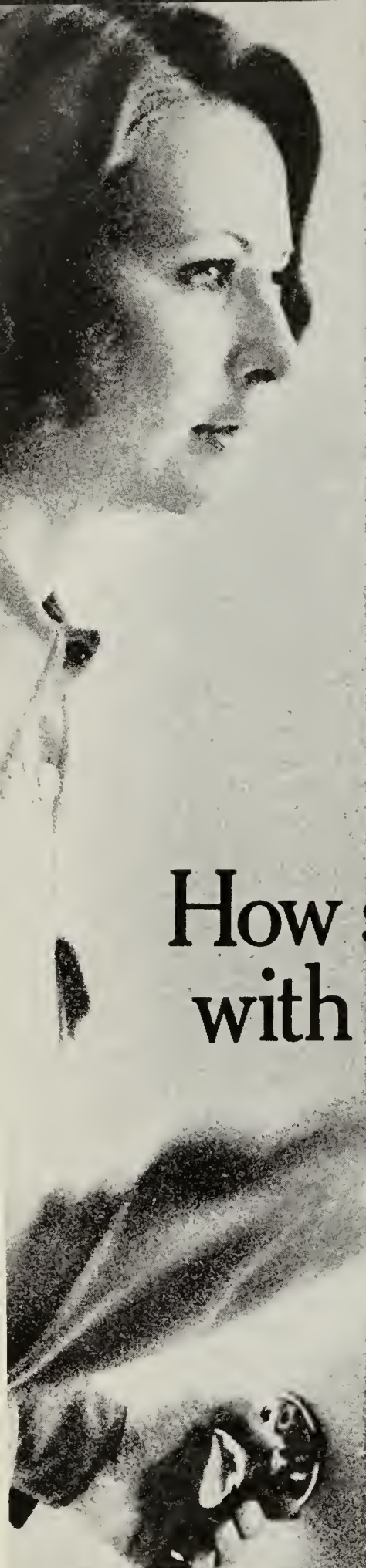
## Southeastern Internists Meet in September

The Southeastern Regional Meeting of the American College of Physicians will be held Sept. 27-29, 1973, at The Cloister, Sea Island, Ga.

The Sea Island session is one of 35 area meetings sponsored for specialists in internal medicine and related fields by the 21,000-member American College of Physicians. It is designed to bring physicians up-to-date on medical advances and to provide continuing educational opportunities for members of the college throughout the United States and Canada.

In charge of arrangements for the Southeastern Regional Meeting is Dr. Edwin C. Evans, 340 Boulevard, N.E., Atlanta, Ga. 30312. The Southeastern Region of The American College of Physicians includes Alabama, Georgia, Louisiana, Mississippi, and South Carolina.





Success in preventing recurrence of urinary tract infection usually depends on success in treating the initial infection. And that in turn is closely linked to factors of proper drug, proper dosage, and *proper length of therapy*. Much of the effectiveness of an antibacterial agent used to treat an acute nonobstructed urinary tract infection depends, in fact, upon proper length of therapy. As you know, it is potentially hazardous for a patient to discontinue her medication too soon; on the other hand, overtreatment has no advantage and may even cause adverse reactions.

#### **Total therapy: 14 days**

Some recent studies suggest that therapy in acute nonobstructed urinary tract infections should be continued for 10 to 14 days even

if patients become asymptomatic in 2 or 3 days, as they often do.<sup>1</sup> After inadequate treatment, of course, survival of bacteria can cause a quick recurrence of infection.

The problem of persuading a patient to complete the full course of therapy remains difficult. Perhaps agreeing on the date for a follow-up examination at the end of medication may be the most effective way of convincing a less than enthusiastic patient to continue therapy even after she becomes asymptomatic.

As a urinary antibacterial, Gantrisin (sulfisoxazole) Roche offers your patient important advantages, some of which may help increase patient cooperation.

#### **High urinary and plasma levels**

Therapeutic urinary and plasma concentrations are usually

## How soon will she drop in with a recurrent cystitis...

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms.

**IMPORTANT NOTE:** *In vitro* sensitivity tests not always reliable; must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infec-

tions. Maximum safe total sulfonamide blood level, 20 mg/100 ml; measure levels as variations may occur.

**Contraindications:** Hypersensitivity to sulfonamides; infants less than 2 months of age; pregnancy at term and during the nursing period.

**Warnings:** Safety in pregnancy not established. Do not use for Group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dys-

crasias. Sore throat, fever, pallor, purpur or jaundice may be early indications of serious blood disorders. CBC and urinalysis with careful microscopic examination should be performed frequently.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.



...ched in 2 to 3 hours and can be  
...intained on the recommended  
...4 to 8 Gm/day dosage schedule  
...it's convenient for almost all  
...ients.

### Generally good tolerance

Gantrisin (sulfisoxazole) Roche  
...uses relatively few undesirable  
...ctions, and serious toxic re-  
...ions are rare. Minor reactions  
...e comparatively infrequent, but  
...y include nausea, headache  
...d vomiting. Gantrisin may usu-  
...y be given safely, even for pro-  
...ged periods, in the treatment  
...chronic or recurrent nonob-  
...s tructed cystitis, pyelitis or  
...elonephritis due to *E. coli* and  
...other susceptible organisms.

(See Important Note in sum-  
...ary of product information.)

Complete blood counts and uri-  
...nalyses, with microscopic exami-  
...nation, should be performed  
...requently.

### High solubility

Gantrisin is one of the most solu-  
...ble of all sulfonamides, with both  
...free and acetylated forms highly  
...soluble in the commonly en-  
...countered urinary pH range of  
...5.5 to 6.5. Urine levels have been  
...detected in 60 minutes; thera-  
...peutic levels are usually reached  
...in 2 to 3 hours. About 90% of a  
...single dose is excreted in 24 to  
...48 hours. As with all sulfona-  
...mides, adequate fluid intake must  
...be maintained.

### Economy

Average cost of therapy is still  
...only about 6½¢ per tablet.

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# if she drops out of her therapy too soon?

For acute, chronic or recurrent nonobstructed cystitis, pyelitis, or  
pyelonephritis due to susceptible organisms

begin with  
**Gantrisin**<sup>®</sup>  
sulfisoxazole/Roche<sup>®</sup>



**Usual adult dosage:** 4 to 8 tablets *stat*, 2 to 4 tablets *q.i.d.*

**Adverse Reactions:** *Blood dyscrasias:*  
granulocytosis, aplastic anemia, throm-  
bocytopenia, leukopenia, hemolytic ane-  
mia, purpura, hypoprothrombinemia and  
methemoglobinemia; *Allergic reactions:*  
erythema multiforme (Stevens-Johnson  
syndrome), generalized skin eruptions,  
epidermal necrolysis, urticaria, serum  
sickness, pruritus, exfoliative dermatitis,  
anaphylactoid reactions, periorbital  
edema, conjunctival and scleral injection,  
photosensitization, arthralgia and allergic  
myocarditis; *Gastrointestinal reactions:*

Nausea, emesis, abdominal pains, hepa-  
titis, diarrhea, anorexia, pancreatitis and  
stomatitis; *C.N.S. reactions:* Headache,  
peripheral neuritis, mental depression,  
convulsions, ataxia, hallucinations, tin-  
nitus, vertigo and insomnia; *Miscellaneous*  
*reactions:* Drug fever, chills and toxic  
nephrosis with oliguria and anuria. Peri-  
arteritis nodosa and L.E. phenomenon  
have occurred. Due to certain chemical  
similarities with some goitrogens, diuretics  
(acetazolamide, thiazides) and oral hypo-  
glycemic agents, sulfonamides have

caused rare instances of goiter production,  
diuresis and hypoglycemia as well as thy-  
roid malignancies in rats following long-  
term administration. Cross-sensitivity  
with these agents may exist.

**Supplied:** Tablets containing 0.5 Gm  
sulfisoxazole.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110



# Pulmonary Function Course Scheduled

The Tenth Annual New Orleans International Postgraduate Course for Physicians on "Pulmonary Function in Health and Disease" will be held Dec. 3-6, 1973, according to Dr. Howard A. Buechner, chairman of the course.

The course is sponsored by the American Thoracic Society, the American College of Chest Physicians, Louisiana State University School of Medicine, in New Orleans and in Shreveport, Tulane University School of Medicine, and the Alton Ochsner Medical Foundation and the American Lung Association of Louisiana, Inc. Its administrative sponsor is the Louisiana Thoracic Society. The LTS is accredited by the American Medical Association.

The course's program will consist of lectures, symposiums, demonstrations and group sessions. Specific topics of the course are Spirometry and Lung Volumes, Pulmonary Mechanics with Emphasis on Small Airways Function, Ventilation Perfusion Relationships, Tests of Pulmonary Mechanics Including Body Plethysmography, Closing Volume, and Flow Volume Curves.

Also included in the topics will be individual groups of Spirometry testing, lectures on Pulmonary Hemodynamics—Normal and Disordered, Alveolar Gas Transfer: Diffusing Capacity, Blood Gas Transport and Acid Base Balance and Exercise Testing in the Evaluation of Pulmonary Function Course to be followed by Pulmonary Function Patterns in Occupational Lung Disease.

Dr. Buechner said other topics included in the course are Problems in Predicting Normal Values for Pulmonary Function Tests, The Pathophysiology of Acute Respiratory Failure Secondary to Chronic Pulmonary Disease, Metabolic Functions of the Lung, and Demonstrations of Pulmonary Diffusion Capacity and Blood Gas Analysis.

Tuition for the four-day course is \$135 for physicians and Ph.D.'s, \$85 for allied health personnel, and \$110 for ATS members. Scholarships and travel assistance are often available to residents and fellows through state and local Christmas Seal associations in their home states, Dr. Buechner advised.

The course will be held in the auditorium of Louisiana State University School of Medicine in New Orleans. Course programs, application forms and hotel information are available from the Louisiana Thoracic Society, Suite 1504, 333 St. Charles Ave., New Orleans, La., 70130; Attention: W. Findley Raymond, Executive Director.

## PRESCRIBING INFORMATION Antiminth (pyrantel pamoate) Oral Suspension

**Actions.** Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

**Indications.** For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

**Warnings.** *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

**Precautions.** Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

**Adverse Reactions.** The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

**Dosage and Administration.** *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

**How Supplied.** Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

**ROERIG** 

A division of Pfizer Pharmaceuticals  
New York, New York 10017



If he's making the  
rounds of San Francisco...

# Antivert<sup>®</sup>/25 (25 mg. meclizine HCl) for vertigo\*

Antivert<sup>®</sup> (meclizine HCl) has been found useful in the management of vertigo associated with diseases affecting the vestibular system. It is available as Antivert (12.5 mg. meclizine HCl) and Antivert/25 (25 mg. meclizine HCl) scored tablets for convenience and flexibility of dosage. Antivert/25 (25 mg. meclizine HCl) Chewable Tablets are available for the management of nausea, vomiting, and dizziness associated with motion sickness.

\*INDICATIONS. Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows:

*Effective:* Management of nausea and vomiting and dizziness associated with motion sickness.

*Possibly Effective:* Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

**CONTRAINDICATIONS.** Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12th-15th day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

**WARNINGS.** Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

*Usage in Children:* Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

*Usage in Pregnancy:* See "Contraindications."

**ADVERSE REACTIONS.** Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

**ROERIG**   
A division of Pfizer Pharmaceuticals  
New York, New York 10017

## Miss. Alcoholism Program Makes Grants-in-Aid

In an effort to determine the need for alcoholism services in Mississippi and to make comprehensive alcoholism treatment and rehabilitation resources available to all sections of the state, the Alcohol Abuse and Alcoholism Program of the State Board of Health has begun a grant-in-aid program to various agencies throughout the state, according to Dr. Alton B. Cobb, State Health Officer. The Alcohol Abuse and Alcoholism Program is itself funded through formula grant monies from the National Institute on Alcohol Abuse and Alcoholism and is located within the Division of Mental Health Services under the direction of Dr. Nina B. Goss-Moffitt.

Harold B. Armstrong, supervisor of the Alcohol Abuse and Alcoholism Program, announced that a considerable portion of the 1973 formula grant funds was made available as seed money to regional programs, institutions of higher learning, and others. One of the first grants made was in the amount of \$5,000 to Mississippi State University for the development of the Mississippi Alcohol Safety Education Program (MASEP). MASEP is conducted by the Department of Sociology and Anthropology of Mississippi State with the cooperation of the Governor's Highway Safety Program, the Mississippi Highway Patrol, and the Mississippi State Board of Health. This project, a reeducation school for those arrested for driving while intoxicated, has proved very successful and is now being expanded to several areas in the state.

The largest grant made has been that of \$100,000 for the formation of an Alcohol Abuse and Alcoholism Consortium, made up of Mississippi State University, the University of Mississippi, the University of Southern Mississippi, and Jackson State College. This type of consortium, which has the potential of fulfilling many training and research purposes, is one of the most innovative components of the Alcohol Abuse and Alcoholism Program.

The Division of Comprehensive Health Planning's A Agency in Jackson was the recipient of a \$20,000 grant for the management and maintenance of the Advisory Council to the Alcohol Abuse and Alcoholism Program. The location of this group within Comprehensive Health Planning gives the Alcohol Abuse and Alcoholism Program a closer tie with the entire network of health services in Mississippi.

In order to survey the existing alcoholism resources and the need for further services in various regions of the state, the following agencies received grants: Comprehensive Health Planning, B Agency for Region 9 in Jackson (\$12,000); Comprehensive Health Planning, B Agency for Region 7 in Brookhaven (\$12,000); and Mental Health-Mental Retardation Region 4 in Corinth (\$5,000). In addition, \$5,000 grants were made to Jackson State College for research into drinking habits among blacks and to Dr. Peter M. Miller of the V.A. Hospital for research and treatment of the public inebriate.

One of the top priorities of the Alcohol Abuse and Alcoholism Program has been the training of professional and non-professional personnel to increase the supply of manpower in Mississippi capable of dealing with various aspects of the problems of alcohol abuse and alcoholism. To further this goal, the program has provided a grant of \$3,925 to the Department of Health of the University of Southern Mississippi for a training workshop for teachers and a sum of \$10,000 to the Department of Guidance and Counseling at USM for the training of qualified alcoholism counselors. In addition, 61 persons from Mississippi attended the one-week Southeastern School of Alcohol Studies at the University of Georgia in 1972.

As a pilot project, Mental Health-Mental Retardation Regions 1 and 2 received \$25,000 for the delivery of alcoholism services through the Oxford Mental Health Center. Major thrusts of this project are the development of treatment services relevant to the needs of employed persons with alcohol problems and for those persons attending the DWI Reeducation Schools who require and need treatment or rehabilitation.

By utilizing a major part of the \$397,485 Formula Grant Funds for 1974, the Alcohol Abuse and Alcoholism Program plans to make grants similar in amount and purpose to other regional programs throughout the state. Three grants-in-aid have been approved to date: Mental Health-Mental Retardation Region 3 in Tupelo (\$25,000); Mental Health-Mental Retardation Region 7 in Starkville (\$20,000); and Mental Health-Mental Retardation Region 12 in Hattiesburg (\$20,000); additionally, Meridian Junior College has received a \$10,000 grant for an educational and treatment program.

With these grants, the program hopes to increase the awareness in every community of the problems of alcohol abuse and alcoholism and to stimulate the development of effective, comprehensive programs for those Mississippians affected



by these problems. Anyone interested in further information about details of the grant program or in the Alcohol Abuse and Alcoholism Program should contact Mrs. Margaret Graham, Public Information Specialist for the program, at the Mississippi State Board of Health, P. O. Box 1700, Jackson 39205.

## PMA Foundation Offers Faculty Awards

The Pharmaceutical Manufacturers Association Foundation announced it will continue its faculty development awards in 1974 to help meet manpower needs in clinical pharmacology.

Thomas E. Hanrahan, executive director of the foundation, said the purpose of the award program, which was inaugurated in 1966, is to stimulate teaching, training, and research in the field of clinical pharmacology.

Medical schools are given the opportunity to suggest candidates at the junior faculty level who indicate a "strong determination for a fulltime career in clinical pharmacology, either in a medical school, or related institution, or in the pharmaceutical industry."

The two-year awards to begin July 1, 1974, include variable salary features and other benefits. The deadline for applications is October 1; names of those selected to receive the awards will be announced by December 15.

Hanrahan said recipients will be selected by the foundation's Board of Directors, based upon recommendations from an advisory committee composed of individuals from the pharmaceutical industry, the academic community, and the government.

Awards for 1973 went to three individuals, bringing to 27 the number awarded under the program.

## FDA Urged to Delay Cough Guidelines

Spokesmen for drug companies and physicians' groups have urged the Food and Drug Administration to delay guidelines on what cough and allergy prescription products may contain.

"These products have been used safely and successfully by physicians for decades," the Amer-

ican Medical Association told a FDA hearing. Asking no "precipitous action," the AMA said "there is hardly a citizen who has not received some relief from bothersome symptoms via one or more of these products."

The proposed guidelines cover more than 200 of the most widely prescribed prescription cough and allergy medicines. Specific limitations would be placed on composition such as banning combinations of expectorants and antihistamines. Effect will be to bar continued marketing of many cough and allergy preparations.

Dr. John H. Budd, a member of the AMA Board of Trustees, said the interim guidelines would not serve the public interest. Dr. Budd noted that a FDA panel on over-the-counter drugs is reviewing the OTC situation. "It is apparent that the final monograph that emerges from this review process will have a substantial bearing on the formulation and labeling of prescription as well as OTC drugs . . . and in many respects will determine the related issues," said Dr. Budd.

The proposed interim guidelines were not formulated under the specific requirements of the drug law, he said, "but rather were devised on the basis of subjective judgments made by members of the appropriate drug efficacy study panels."

The AMA official said that if one considers the contribution any one drug may make to a mixture, published evidence as specified in the law does not exist for any of the classes of drugs in cough mixtures: antitussives, expectorants, antihistamines, decongestants, demulcents or flavorings.

"The problem that confronts us is not a simple straightforward one such as determining the effect a drug has on bacterial multiplication, urine output or level of a plasma constituent. Rather we are in the difficult area of subjective human feelings, symptoms with profound psychological as well as physical parameters. The remedies for cough were developed by trial and error over decades and even hundreds of years. The long history behind the expectorant ingredients . . . have put them, in the doses used, to the test of safety and by the impressions of clinicians to the test of effectiveness. How effective they are is difficult to measure since for cough the placebo effect is extremely important. Many coughs respond simply to a drink of water. Other coughs respond to expectorants. Still others respond only to substantial doses of codeine or an equivalent antitussive, and finally some coughs will yield to nothing yet devised."

## Continuing Med Education Programs Scheduled

Beginning with this issue, JOURNAL MSMA will begin publishing regularly the schedules of upcoming medical education programs distributed by the Network for Continuing Medical Education (NCME).

NCME is an educational television service for some 100,000 physicians at over 650 hospitals and medical centers across the country.

In Mississippi the following are served by NCME: University of Mississippi School of Medicine (Dept. of Psychiatry), Jackson; Veterans Administration Hospital, Jackson; and Mississippi Regional Medical Program, Jackson.

Every two weeks hospitals in the network receive one-hour videotapes containing new programs on three or more medical subjects. These programs, predominantly clinical in nature, are approved for accreditation by the American Medical Association and the American Academy of Family Physicians.

Supported by Roche Laboratories, NCME provides programs without charge in most two-inch, one-inch and half-inch reel-to-reel videotape formats. Videocassettes, which may be kept, are optional at a modest fee.

As a supplement to its regular service, the NCME Master Library makes some 600 programs available on a rental or purchase basis.

For further information, contact NCME, 15 Columbus Circle, New York, N. Y. 10023.

### SCHEDULE OF UPCOMING NCME PROGRAMS

Here are playing dates and upcoming programs to be distributed by The Network for Continuing Medical Education (NCME):

- Aug. 13-Sept. 9 *Screening Pre-Schoolers for Neurological Deficits*, with N. Paul Rosman, M.D., Boston University School of Medicine and Boston City Hospital.  
*Stasis Ulcers of the Ankle*, with Robert A. Nabatoff, M.D., Mount Sinai Medical Center, New York City.  
*Abdominal Arteriography*, with Robin Craid Watson, M.D., Cornell University Medical Center

Sept. 10-23

and Memorial Sloan-Kettering Cancer Center, New York City.

*The Hyperactive Child: Finding the Cause*, with Gerald Erenberg, M.D., Montefiore-Morrisania Hospitals, New York City.  
*Endoamniotomy: Inside the Future*, with Carlo Valenti, M.D., State University of New York Downstate Medical Center, Brooklyn, N. Y.

*Early Surgery for the Arthritic Hand*, with Alan W. Wilde, M.D., Cleveland (Ohio) Clinic.

Sept. 24-Oct. 7

*Managing the Hyperactive Child*, with Gerald Erenberg, M.D., Pediatric Neurologist, Montefiore Medical Center and Morrisania Hospital, Bronx, N. Y.

*U. S. Acupuncture: Status Report, 1973* with physicians and scientists from Boston, Cincinnati, Los Angeles and Canoga Park, Cal., New York City, St. Louis and Washington, D. C.

*Antibiotic Misadventure: "The Case of Overkill,"* with Harold C. Neu, M.D., Chief of Infectious Diseases, Columbia University College of Physicians and Surgeons, New York City. (A Drug Spotlight Program feature.)

Oct. 8-21

*How to Overdiagnose Pulmonary Embolism*, with Edward H. Morgan, M.D., Head, Respiratory Disease Section, The Mason Clinic, Seattle, Washington.

*What You and Your Patient Should Know About Coronary Arteriography*, with F. Mason Sones, Jr., M.D., Director of Cardiovascular Medicine and Cardiac Laboratory, and Donald B. Effler, M.D., Director, Department of Cardiovascular and Thoracic Surgery, both of The Cleveland Clinic.

*Antibiotic Misadventure: "The Case of Superinfection, Par Excellence,"* with Harold C. Neu, M.D., Chief of Infectious Diseases, Columbia University College of Physicians and Surgeons, New York City. (A Drug Spotlight Program feature.)



## Nose Plastic Surgery Course Set

An advanced continuing education workshop in "Plastic Surgery of the Nose: Rhinoplasty and Reconstruction" will be held Sept. 29-Oct. 3, 1973, under the direction of Dr. M. Eugene Tardy, Jr.

The course is jointly sponsored by the Department of Otolaryngology, University of Illinois Medical Center, the American Academy of Facial Plastic and Reconstructive Surgery, Inc., and Saint Joseph Hospital, Chicago.

Refinements in plastic and reconstructive surgery of the nose, including rhinoplasty, will be discussed and demonstrated by the faculty. Closed circuit color television surgery will provide live surgical demonstrations. Nasal reconstruction topics include acute nasal trauma, skin grafts, local and regional flaps, dermabrasion, cryosurgery, burns, scar camouflage, implants, bone and cartilage grafts, composite grafts and prostheses. Topics considered in rhinoplasty include photography, analysis, dynamics, psychiatric evaluation, incisional approaches, hump removal and osteotomies, surgical anatomy, tip refinements, cleft lip-nose complex, columellar deformities, septoplasty, complication avoidance.

For brochure and applications, write Dr. M. Eugene Tardy, Jr., Course Director, Department of Otolaryngology, Eye and Ear Infirmary, 1855 W. Taylor, Chicago, Ill. 60612.

## Psychiatric Drugs Help Prevent Relapse

A multi-clinic, NIMH research project in Maryland shows that continued use of psychiatric medication in the post-hospital treatment of schizophrenic patients is highly effective in preventing relapse.

Principal investigator Gerard E. Hogarty, chief of Social Science Research at Friends Medical Science Research Center in Baltimore, is continuing the study under a grant from the National Institute of Mental Health, of HEW's Health Services and Mental Health Administration.

Hogarty and his colleague, Dr. Solomon C. Goldberg, of NIMH's Psychopharmacology Research Branch, initiated the study to provide evidence on how two modes of treatment-drug medication and sociotherapy—interest in the preven-

tion of relapse. The team also sought to test the effect of continued drug use in improving social adjustment among the discharged patients.

The investigators found that only 31 per cent of the patients being given a major tranquilizer were rehospitalized during the first year following discharge, a rate less than half of that for patients receiving a dummy medication.

Participating in the study were 374 patients treated for schizophrenic disorders at three Maryland State Hospitals serving the Baltimore area. Following discharge, patients were grouped and assigned to one of four treatment regimens. These included drug alone (Thorazine), drug with sociotherapy (social casework and vocational rehabilitation counseling), placebo alone, and placebo with sociotherapy.

Neither doctor nor patient knew which medication was being used. This research procedure, known as "double blind," is designed to lessen the possibility of bias.

In the January issue of the *Archives of General Psychiatry* the investigators reported that all patients, whether on drugs or placebo who were not rehospitalized within six months, were adjusting equally well. After six months, however, placebo patients began to relapse at a rate twice that of those who received drugs.

The researchers suggested that the drug should be maintained for its long-term preventive value as well as for its immediate therapeutic effect. Although psychiatric drugs are frequently prescribed for patients after discharge, if discontinued when the symptoms become less obvious, the drugs' full potential is nullified.

The project is also contributing to a fuller understanding of the aftercare process as a whole. The data indicates that psychotherapies used in the aftercare of mentally and emotionally disordered patients might require at least a year to show a noticeable effect.

Although average lengths of hospitalization have decreased dramatically since psychotherapeutic drugs were introduced in the mid-1950's, the frequent rehospitalization of patients has become a major problem. The NIMH-supported study is the first comprehensive effort to prove the preventive value of drugs in the post-hospital care of patients.

Later phases of the study will describe relapse rates in the second year following discharge. The team also plans to analyze further the effects of various treatment approaches and why patients arbitrarily stop taking prescribed medication.



**Because you  
practice  
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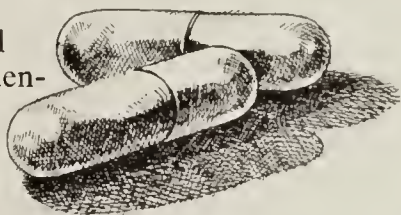




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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions

in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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## ORGANIZATION / Continued

# Care of Injured Seminar Set

Approximately 125 physicians are expected to attend a four-day seminar on "Life-Saving Measures for the Critically Injured," sponsored by the American College of Surgeons' Committee on Trauma and the department of surgery of the University of Tennessee College of Medicine, Memphis, on Nov. 14-17, 1973.

This seminar at Shrier Auditorium is one of 16 being held throughout the U. S. during 1973-74 by the Trauma Committee in cooperation with departments of surgery of medical schools. It is designed particularly for rural and general practitioners, physicians called upon most frequently to render primary medical care to the injured. Though aimed at the non-specialist and emergency department physician, the broad curriculum is useful also for surgical specialists and internists.

Dr. Harwell Wilson, professor and chairman, department of surgery, University of Tennessee, is course director. Assisting him are Drs. James W. Pate, professor, and Louis Britt, associate professor, both of the department of surgery.

A faculty of 26 experts in the field of trauma, serving as "teachers," will report on the latest in care of the injured. All but four are members of the University of Tennessee faculty.

Lecturers from outside the university include Dr. C. Thomas Fitts, associate professor of surgery, Medical College of South Carolina, Charleston, speaking on "Assessment of the Critically Injured Patient"; Dr. Roger T. Sherman, professor and chairman, department of surgery, University of South Florida, Tampa, "Pathophysiology of Shock—Clinical Correlations"; Dr. James D. Hardy, professor and chairman, department of surgery, University of Mississippi, Jackson, "Overview of Management of Critically Injured"; and John J. Thomason, attorney, Memphis, "Avoiding Medico-Legal Problems in the Critically Injured."

Other topics to be covered include: ventilation of the injured patient; initial care of soft tissue wounds; care of the multiple injury patient; pulmonary physiology; laryngeal injuries; severe injuries of the face; blunt and penetrating blood vessel injuries of the lower extremity, abnormal injuries, head and spinal cord injuries; fractures and dislocations; genito-urinary tract injuries; blood and electrolyte replacement in the severely injured; blood vessel injuries of torso, base of neck and upper extremity; burns; trauma and

renal function; coagulation and transfusion problems; metabolic effects of trauma-hyperalimentation; the injured child; priorities in the multiple injury patient; post traumatic pulmonary insufficiency; use and abuse of drugs affecting the cardiovascular system, and unusual traumatic deaths.

Dr. Oscar P. Hampton, Jr., director of the Trauma Division of the ACS, provides staff support for all trauma programs of the college. Financial support for this series of seminars is being provided under contract number NIH-72-4393, Public Health Service, HEW.

This seminar is approved by the American Medical Association for credit toward Physician's Recognition Award, by the American College of Emergency Physicians for continuing education credit for members, and by the American Academy of Family Physicians for 27 hours of credit. Registration fee is \$75 (includes three luncheons, reception, banquet, and copy of book, *Early Care of the Injured Patient*).

Other sites for 1973 include Dallas, San Francisco and Denver.

## Mead Johnson Markets Questran

Mead Johnson Laboratories has announced that marketing of Questran (cholestyramine) for the lowering of serum cholesterol levels will begin immediately according to Dr. James M. Tuholski, president, Mead Johnson & Company.

Questran lowers serum cholesterol levels in one of the commonest occurring types of hypercholesterolemia.

Questran has been on the market since 1967 for relief of pruritus—an intense itching associated with partial biliary obstruction which causes excessive concentrations of bile acids in the blood and skin.

Mead Johnson has conducted numerous clinical studies since 1963 to determine the effectiveness of Questran in lowering cholesterol in man.

The active ingredient in Questran is an anion exchange resin which binds bile acids in the intestine, prevents them from being reabsorbed and thereby increases their excretion. Bile acids are made in the body from cholesterol and are a major form in which cholesterol is eliminated from the body. Increasing the excretion of bile acids thus lowers the serum cholesterol level.

Questran is in a powder form which is mixed with a beverage such as water, milk, fruit juice, carbonated drink and soups. Or, it may be consumed with moist pulpy fruits such as applesauce.



# Cancer Detection Day Yields Results

At least five unsuspected cases of colon-rectum cancer—the second leading cause of cancer deaths—have been detected and are now being treated as the result of a one-day public screening program in Mercer County, New Jersey.

Discovery of the cancers was reported by Dr. James Hastings of Princeton, who headed the mass screening of some 3,400 persons that began with a Cancer Detection Day on June 1, 1972.

Although final data has not yet been compiled, Dr. Hastings disclosed that in addition to the cancers, 10 per cent of those examined had disorders requiring medical attention. The other disorders included diverticulitis, hemorrhoids and prostatic disease.

"We have seen too many deaths from colon-rectum cancer," Dr. Hastings commented. "And in the past, surgeons like myself have been quite disillusioned and disappointed by the stage in which many of these patients came to us.

"We tried this program because we wanted to test a program of rapid mass screening to detect those people most likely to have colon-rectum cancer. We wanted to detect it at a stage where successful treatment is possible. I am optimistic about what we have accomplished."

Cancer Detection Day in Mercer County was a volunteer venture by the Cancer Committee of the Mercer County Medical Society, chaired by Dr. Hastings, a general surgeon, and the Mercer County Unit of the American Cancer Society. Participants included over 90 doctors and several hundred nurses. Hospitals, private industry and government also cooperated.

The volunteers set up 15 physical examination centers—five in hospitals, four in community centers, three in government buildings and three in industrial facilities. The centers were visited on June 1, 1972, by 3,450 persons.

Of the visitors, 2,933 availed themselves of a digital rectal examination. All visitors—whether or not they had a physical—were given three "Hemoccult" slides and dietary instructions to take home. They were instructed to mail completed slides to the cancer society.

Dr. Hastings said that 2,642 persons returned "Hemoccult" slides following the June 1 effort. Examination disclosed positive results on one or more slides returned by 159 persons.

These 159 then received letters advising them to go to their physicians for a thorough physical,

including a barium enema, which Dr. Hastings said would have been impractical on a mass basis.

One hundred and twenty-one of the 159 responded to the letters. But only 52 have thus far undergone complete physicals, including the barium enema.

In the group of 52, physicians discovered five asymptomatic, unsuspected bowel cancers, as well as other disorders such as diverticulitis and polyps. The examinations, which discovered the cancers, were a result of positive slide readings.

Thirty of the 52 were found to be false positives—a positive reading where the site of gastrointestinal bleeding could not be found. The high false positive rate was attributed by Dr. Hastings to a failure by the patients to follow the prescribed meat-free, high roughage diet.

## Industrial Health Conference Planned

The Florida Industrial Health Conference and Southeastern Industrial Health Conference is set for Nov. 1-3, 1973, at the Holiday Inn-Downtown in Tampa, Fla.

For information write Dr. Eugene L. Horger, IBM Corporation, 85E002, 2000 51st Street, Boca Raton, Fla. 33432.

## Emergency Care Seminar Set for New Orleans

The fourth annual Seminar on Areawide Emergency Medical Services will be held Sept. 6-7 at the Hotel Marriott in New Orleans.

The program is designed to inform state and local government officials, hospital administrators, ambulance providers, and others about current trends, procedures and techniques for establishing a coordinated emergency medical service system.

The seminar is sponsored by the American College of Surgeons' Committee on Trauma and presented by the Louisiana chapter.

The registration fee of \$50.00 includes lunches, social hour and meeting packets. Checks should be made payable to Oklahoma Trauma Research Society, Inc., and mailed to 915 Warren Professional Building, 6465 South Yale, Tulsa, Oklahoma 74136.

## Albany Plans Medical Cruise

The Department of Postgraduate Medicine of Albany Medical College announces that reservations are now being accepted for the Fifteenth Postgraduate Medical Seminar Cruise, Jan. 26-Feb. 9, 1974.

The 14-day cruise will depart from New York aboard the luxurious ship "Rotterdam" of the Holland-American Line.

Ports of call will include St. Maarten, Montserrat, Barbados, Trinidad, Martinique, Puerto Rico and the Virgin Islands of St. John and St. Thomas.

Faculty of the Albany Medical College will present a shipboard postgraduate program emphasizing medical topics of particular interest to general internists and family practice physicians.

Request has been made for continuation study credit by the American Academy of Family Practice.

For information write to: Dr. Frank M. Woolsey, Jr., Department of Postgraduate Medicine, Albany Medical College, Albany, N. Y. 12208.

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## "No Smoking" Signs Are Available

The Mississippi Lung Association, formerly Tuberculosis and Respiratory Disease Association, offers special "No Smoking" signs to physicians, hospitals, and clinics free of charge.

Two sizes are available: a small desk fold-over stand-up style 2" x 4" or a large wall size 11" x 14" in either paper or heavier cardboard. The signs are printed in colorful red, white, and blue on a white background, and they read: "THANK YOU FOR NOT SMOKING."

Please contact the Mississippi Lung Association, Post Office Box 9865, Jackson, Miss. 39206 for the size and number desired.

## Alcoholism Society Holds Meeting

The American Medical Society on Alcoholism is holding its Fourth Annual Meeting at the Sheraton-Valley Forge Hotel, Valley Forge, Pa., Sept. 28-30, 1973, "Alcoholism 1973."

The program will include a series of short informational sessions designed for the physician who is faced with the problem of diagnosis and the treatment of the chronic illness and acute exacerbations and complications.

For further information write: American Medical Society on Alcoholism, Suite 1720, Two Park Avenue, New York, N. Y. 10016.

## Pan-Pacific Surgical Group Meets in 1975

The thirteenth congress of the Pan-Pacific Surgical Association will be held Feb. 15-21, 1975, at the Hilton Hawaiian Village Hotel in Honolulu.

Concurrent meetings will be held in anesthesiology, colon and rectal surgery, general surgery, neurosurgery, obstetrics and gynecology, ophthalmology, orthopedic surgery, otolaryngology, plastic surgery, thoracic-cardiovascular surgery and urology.

For details write Dr. Cesar B. DeJesus, Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.



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■ OCTOBER 1973

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Volume XIV

Number 10

October 1973



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# Pinworm therapy is often a family affair



**Contraindications:** History of hypersensitivity to thiabendazole.

**Warnings:** If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.

**Precautions:** Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction,

patients should be carefully monitored.

**Adverse Reactions:** Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopenia; malodor of the urine, crystalluria, hematuria; appearance of live *Ascaris* in the mouth and nose. Hypersensitivity reactions





ORIGINAL PAPERS

## Respiratory Failure in Chronic Airways Obstruction

JOE R. NORMAN, M.D.,  
CAMILLA A. PROCTOR, M.D., and  
A. WALLACE CONERLY, M.D.  
Jackson, Mississippi

*The Conservative Approach—Continuous Low-Flow Oxygen Therapy.* If mammalian lung serves primarily to arterialize mixed venous blood, it seems justifiably correct to detect failure of this function in systemic arterial blood. Until recent years, however, blood gas measurements were considered difficult to perform and generally were not available to the clinician who found with increasing frequency, the necessity of diagnosing and treating this type of organ failure. Today, the availability and reliability of arterial blood gas measurements, utilizing the polarographic systems as ingeniously devised by John Severinghaus and others, now dictate that there is no need for a physician to determine on the basis of his clinical judgement, the patient's need for oxygen or external ventilatory support. Indeed, the clinical signs and symptoms of respiratory insufficiency are so non-specific that failure to utilize these determinations is fraught with profound therapeutic hazard. We have chosen to define respiratory failure in terms of abnormal arterial blood gas tensions as a condition characterized by a substantial decrease in the  $PO_2$  (less than 50 torr) and which is usually, but not invariably, accompanied by an increase in the  $PCO_2$  (greater than 50 torr). This diagnosis is by no means limited to primary diseases of the lung parenchyma but should be thought of in numerous and diverse clinical circumstances which vary from myxedema

coma to acute blood loss. Each cause of respiratory insufficiency presents its own set of therapeutic problems. Except where otherwise speci-

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*The authors discuss the conservative approach, continuous low-flow oxygen therapy, in patients with respiratory failure in chronic airways obstruction. They also describe additional therapeutic measures in the management of respiratory failure and emphasize that they must be accompanied by efforts to correct associated acid-base and electrolyte abnormalities. Systemic antibiotics, aerosol therapy, postural drainage, corticosteroids and exercise therapy are covered.*

---

fied, this discussion of the conservative approach will be limited to the management of chronic airways obstruction, commonly referred to in this country as bronchitis and emphysema or chronic obstructive lung disease.

Within this boundary, the discussion will be concerned just as much with prevention as with treatment of respiratory insufficiency. By prevention and treatment we mean the continuous administration of a low concentration of oxygen in a carefully controlled, continuous fashion. Our experience confirms that of others and suggests that as long as the patient breathes room air and is given no sedation, the  $PCO_2$  is seldom likely

---

From the Department of Medicine, Division of Pulmonary Diseases, University of Mississippi Medical Center, Jackson, Miss.

to rise above 70 torr. However, the PCO<sub>2</sub> may rise much higher if high concentrations of inspired oxygen are allowed, if oxygen is given intermittently, or if sedation is given.

When clinical suspicion is aroused, arterial puncture is indicated. We can think of no contraindication to arterial puncture in any patient presenting with either acute or chronic pulmonary complaints, and to justify the efficacy of subsequent oxygen therapy without serial determinations of the PO<sub>2</sub> is unheard of. No special technique or equipment other than a heparin syringe and needle are required. We prefer either the brachial or the radial artery, and if a firm pressure is applied for a three-minute period after the needle is withdrawn, complications are rare. We have kept percutaneous needles in place for periods of time up to 72 hours and longer without serious difficulty, but they do require special attention and the demonstration of a competent ulnar arterial supply (Allen test). They must be properly anchored so as to minimize the hazard of dislodgement by movement, be flushed intermittently with 1-2 ml of dilute heparin (more vigorous flushing with larger quantities may produce cerebral emboli) and be closely observed to prevent unsuspected detachment of connections.

It is customary in some institutions to be more concerned with the determination of the PCO<sub>2</sub> and pH than with the oxygen tension value. We take issue with this and express the opinion that the paramount therapeutic problem concerns the correction of arterial hypoxemia. *What these patients require is oxygen!* Our therapeutic approach then is the re-establishment of a tolerable level of arterial oxygen tension which is commensurate with the least rise in arterial PCO<sub>2</sub>. We constantly refer to and are guided by serial determinations of PO<sub>2</sub>, PCO<sub>2</sub>, pH and bicarbonate. Monitoring systems in other hospitals include the mixed venous PCO<sub>2</sub> determination, utilizing the re-breathing technique of Campbell and Howell, and the Astrup system. Our own experience with the re-breathing technique, particularly in a comatose patient, has not been satisfactory. Newer systems (buffer base) and the Astrup calculation of "standard bicarbonate" and "base excess" are said to have special advantages over the traditional measurements, but we feel at times the Astrup nomogram may be exceedingly misleading and of dubious therapeutic value.

The first question to be answered is "what is the tolerable level for arterial oxygen tension in man?" A critical value cannot be defined for all tissues at all times. By critical—is meant the nec-

essary gradient for the transfer of oxygen to be accomplished from capillaries to tissues. It seems reasonable to consider an average critical range to be somewhere between 20-30 torr. If one chooses to define "tolerable" hypoxemia in terms of anaerobic metabolism, there is no significant change in the lactate/pyruvate ratio in the chronically hypoxic subject until the PO<sub>2</sub> falls below 40 torr. In either event, the human organism seems moderately tolerant of low PO<sub>2</sub> values, but because arterial blood serves as an important reservoir for oxygen, the hypoxic subject stands in peril if any further compromise of his ventilation occurs. Hypoxemia, even the slightest, brings about adaptive effects on the circulation and respiration. These effects, particularly in the pulmonary circulation, are magnified when hypercapnea is superimposed. Cyanosis is the least reliable index of arterial unsaturation and is not reliably detected until the oxygen tension falls to about 50 torr which is only a few torr above the intolerable zone. It is generally agreed that the aim of oxygen therapy should be a PO<sub>2</sub> of approximately 50-60 torr.

In respiratory failure secondary to chronic airways obstruction, it is essential that oxygen administration be *continuous*. Continuous oxygen therapy is essential for the following reason. If underventilation occurs when oxygen is administered, alveolar and arterial PCO<sub>2</sub> will rise and if oxygen is stopped while the PCO<sub>2</sub> is elevated, the PO<sub>2</sub> will fall to a level lower than that prior to therapy. Most patients with respiratory failure of this type are not able to compensate by increasing ventilation and when oxygen is discontinued become significantly more hypoxemic. Intermittent oxygen therapy substitutes periods of severe hypoxemia for tolerable oxygen levels. It is dangerous and should not be employed. This does not mean that patients should be immobilized; in fact, they should be encouraged to move about *with* supplemental oxygen going at its usual rate. We use the biprong cannula with sufficient oxygen line so that the patient can be mobilized. It is necessary that the flow meter be taped at the desired setting, and that all personnel and *the patient* understand the necessity for maintaining an exact flow. The necessary supplement is determined by trial (1-3 L/min 100 per cent oxygen) and serial arterial blood samples drawn approximately 20 minutes after each change in inspired oxygen concentration. Patients with respiratory failure rarely have a PCO<sub>2</sub> greater than 70 torr, or a hydrogen ion concentration in excess of 70 nanomoles per liter as long as room air is breathed or as long as supplemental in-



spired oxygen is adjusted to give a  $\text{PaO}_2$  of no greater than 60 torr. Because of ventilation/perfusion "scatter," there is no way to accurately predict the inspired supplement which will insure this  $\text{PO}_2$  value so repeated sampling is necessary.

Again, severe respiratory acidosis can usually be avoided if the concentration of inspired oxygen is carefully monitored, and if no sedation is given. An alternative method for constant administration of a known amount of oxygen is the Venti-Mask (modified venturi face mask) which accurately entrains room air and mixes it with 100 per cent oxygen in an amount stated by the manufacturer to deliver either 24 per cent, 28 per cent, or 32 per cent oxygen. As is true with low-flow oxygen via biprong (because most of the inspired gas is room air), no additional humidity is needed. The chief problem with the Venti-Mask is poor patient acceptance with resultant inconstant administration. Sedation must be avoided. *There is no safe hypnotic, analgesic or tranquilizing agent for the patient in respiratory failure.* Despite claims to the contrary, Talwin, a brand of pentazocine, can cause severe respiratory depression after a relatively modest dose.

There may be some rationale for combating hypercapnea in the long-term management of patients with respiratory insufficiency. The necessity, however, of reversing moderate elevations of  $\text{PaCO}_2$  is not clearly established. Coma is rarely seen in patients presenting to hospitals unless they have received a high concentration of inspired oxygen, or unless they have been sedated. Additional central nervous system manifestations indicative of respiratory acidosis include restlessness, headache, and drowsiness, and may provide an indication that conservative therapy is failing.

Doxapram administered intravenously has been shown to be a useful therapeutic adjunct in the management of patients where oxygen therapy may be expected to worsen hypercapnea and acidosis. Doxapram hydrochloride (A. H. Robins) may be diluted in 5 per cent dextrose in water at a concentration of 2.8 mg/ml and infused at a rate of 1 ml/min. This form of therapy may be continued for 24-48 hours and toxic reactions (restlessness and agitation) are uncommon. The decision in favor of external ventilatory support is a difficult one and Doxapram may allow the physician time to institute additional therapeutic modalities and diagnostic evaluation. Furthermore, intubation and external support might be delayed until more experienced personnel are available. Doxapram could also allow the patient to be safely transported to a special care facility while receiving low-flow supplemental oxygen.

### *Additional Therapeutic Measures in the Management of Respiratory Failure*

Today, the practicing physician is literally bombarded by advertisements for a variety of complex breathing machines and pharmacologic agents said to be of benefit in chronic obstructive lung disease. Most, if not all of these claims, are unsubstantiated. Positive pressure machines, humidifiers and vaporizers are expensive, and sympathomimetic agents administered by positive pressure are frequently ineffective and sometimes associated with frightening adverse side effects, including tachyarrhythmias, myocardial infarction and sudden death.

The use of ancillary therapeutic modalities in the management of respiratory failure will be safe and effective only when the physician has a clear understanding of the disordered pathophysiology of chronic airways obstruction. A careful distinction must be made between those therapeutic measures which may be useful or helpful in acute respiratory failure, and measures which should be reserved for patients less acutely ill, and for those requiring long-term out-patient care. As the individual patient improves from an episode of acute respiratory failure, the physician must graduate his care in preparation for early mobilization and subsequent hospital discharge. For example, effective postural drainage is difficult for the acutely breathless patient with thick retained tenacious secretions. On the other hand, postural drainage is most effective in the less acute situation once secretions have been liquified.

The ancillary modalities will serve no end unless meticulous attention is directed toward correcting associated acid base and electrolyte abnormalities. Patients in respiratory failure frequently demonstrate complex acid base derangement and significant electrolyte disturbances. If respiratory failure develops slowly over several days, renal compensation provides for tubular secretion of hydrogen ion, reabsorption of filtered bicarbonate with loss of both chloride and potassium in the urine; consequently, metabolic alkalosis frequently accompanies respiratory acidosis and the respiratory acidosis will not be corrected until potassium and chloride are replenished. Increase in plasma bicarbonate from renal sources serves to defend arterial pH as the  $\text{PCO}_2$  rises with worsening respiratory failure; therefore, acid base derangement in this circumstance is less pronounced although the electrolyte changes may be striking. With severe hypokalemia, hypochloremia and a high serum bicarbonate, it is easy to see why the pH may be frankly alkaline in the presence of a high  $\text{PCO}_2$  in respiratory failure. These

electrolyte abnormalities are frequently compounded by vomiting and by the use of potent diuretics.

Body resources are ill-equipped to defend sudden increases in the PCO<sub>2</sub> when ventilation is acutely impaired, indeed only a few milliequivalents of bicarbonate are generated from extra renal sources. Here pH is not defended, acidosis is severe, and because of accompanying hypoxemia, lactic acidosis is usually superimposed. Except for the low or frequently normal bicarbonate, serum electrolytes may be entirely unremarkable, but acidosis severe and therapeutic implications more urgent.

Meticulous attention must be paid to inspired oxygen concentrations when ancillary modalities are employed, and it should be administered as previously described. *Continuous low-flow oxygen must not be interrupted for IPPB treatments, and especially IPPB machines should not be powered by 100 per cent oxygen sources.* This defeats the purpose of low-flow therapy; results in intermittent oxygen therapy, abolishes the hypoxic respiratory drive, and causes the PCO<sub>2</sub> to rise to dangerous levels with ensuing respiratory and metabolic acidosis. If IPPB therapy is employed, biprong low-flow oxygen must be continued, and the positive pressure machine powered by compressed air. There are at least five useful modalities which may be employed at times in addition to continuous low-flow oxygen and Doxapram in acute and chronic respiratory failure in chronic obstructive lung disease; they are systemic antibiotics, aerosol therapy (including IPPB), postural drainage, corticosteroids and exercise therapy.

#### SYSTEMIC ANTIBIOTICS

Most episodes of acute respiratory failure in bronchitis are related to recurrent bronchopulmonary infections, either viral or bacterial in character. Patients with bronchitis and emphysema are unusually susceptible to viral respiratory illnesses which frequently predispose to bacterial infections. The pulmonary defense mechanisms including mucociliary function and the in situ detoxification mechanisms are abnormal in these patients and antimicrobials alone frequently insufficient to overcome these deficiencies. Adequate oxygenation, hydration and ventilation are important for proper functioning of the pulmonary defense mechanisms. With increasing recognition of hospital and community acquired gram-negative infections, especially in the critically ill, the sputum smear becomes a valuable determinant of antibiotic selection. Expecterated material may

be difficult to obtain, and the physician may need to encourage coughing by means of vigorous chest clapping or resort to nasotracheal suction in an effort to obtain suitable material for examination by gram stain. On the basis of the initial sputum smear, a judgement should be made as to whether the predominant flora is gram-positive, gram-negative or indeterminant. In the moderately ill patient with either predominant gram-positive sputum or in sputum with no predominant organisms, we prefer tetracycline or low-dose penicillin. High-dose penicillin therapy is often associated with bacterial superinfection and best be avoided. We continue tetracycline or penicillin for a full 7-10 days. Additional antimicrobial therapy will be based on the patient's response to initial therapy and report of sputum cultures and sensitivities.

Ampicillin is often recommended since Hemophilus influenza is frequently cultured from the sputum but the etiologic importance of Hemophilus is difficult to document, especially if it is present in small numbers. No comparative studies are available regarding the efficacy of penicillin, ampicillin or tetracycline where distinction is made of mild, moderate or severe illness. The increasing incidence of resistance of gram-negative organisms of the Enterobacter group to ampicillin is of concern and is likely related to its indiscriminate use. We reserve cephalothin for the more acutely ill patient in respiratory failure or when indicated by antibiotic disc sensitivity. Gentamycin has been effective and, indeed, life-saving in the treatment of gram-negative pneumonia when given in accordance with the manufacturer's recommendations and in adjusted doses consistent with changing renal function. Although the necessity for antibiotics in severe infection is well documented, the value of any type therapy for usual or moderate exacerbations of bronchitis has been questioned. Unfortunately, there are no long-term benefits of antibiotic therapy.

#### AEROSOL THERAPY AND IPPB

The application of therapeutic aerosols is a highly technical form of treatment with many complicating factors and with varying degrees of effectiveness. The spectrum of nebulization therapy includes IPPB with bronchodilator material, the use of bland and occasionally mucolytic aerosols. Bronchodilator therapy has received wide acceptance in medicine since its introduction for use in asthma in 1935. The number of available sympathomimetics, xanthines, their methods of administration and claims by both pharmaceutical houses and machine manufacturers, must be



carefully examined by the physician, especially in light of recent evidence suggesting worsening physiologic parameters which include a significant fall in arterial oxygen tension following aerosol therapy. Today, even the smallest hospital may have an inhalation therapy service, or indeed, an entire department, yet that same hospital may not have reliable arterial blood gas determinations available to the attending physician 24 hours a day.

In most, if not all instances, bronchodilator therapy may be effectively administered by a small motor-driven compressor (or even a hand bulb nebulizer) rather than by an IPPB device which costs the patient from \$5 to \$20 per treatment in most hospitals. In other instances, patients too ill to use these devices may be benefited by IPPB when treatments are given by a trained technician, especially if treatments are followed by vigorous chest clapping, shaking, and postural drainage. The specific device for bronchodilator administration is probably less important than the correct use of bronchodilator substance.

Home treatment with IPPB has been advocated to improve alveolar ventilation, improve bronchodilatation, improve air distribution, and reduce the work of breathing by decreasing airways resistance. It is important for the physician in evaluating these results, to differentiate the response to IPPB per se from response to administration of bronchodilator material by IPPB. Several important studies have now clearly shown no short-term effects after six days of treatment, four times daily, with or without Isoprenaline. Additionally, no demonstrable benefit has been recorded over periods averaging more than four years with IPPB of compressed air, four times daily in large numbers of patients with chronic airways obstruction. The rationale that IPPB provides a more effective mode of administering bronchodilators than nebulizers has no validity since it has been repeatedly shown that various methods of administering bronchodilator aerosols fail to alter the response significantly.

Both sympathomimetic amines and the xanthines act by increasing tissue levels of AMP (adenosine monophosphate) with resulting stimulation of beta adrenergic receptors in the lung. This relaxes smooth muscle fibers in all the airways and tends to produce bronchodilator action. Therapeutic doses of sympathomimetic amines (usually less than 100  $\mu\text{g.}$ ) are rarely accompanied by significant side effects. For Isuprel (isoproterenol hydrochloride) the recommended dose is 250 to 1,000  $\mu\text{g.}$  and the peak response is reached within 15 minutes although the duration of ac-

tion is greater than one and one-half hours. This dose should be diluted with distilled water or saline to two or four times the initial volume, and given for 8 to 20 deep breaths. Vaponefrin, which contains racemic epinephrine may be administered in a dose of 200-700  $\mu\text{g.}$ , but has a double peak response and makes subsequent therapy unpredictable. Aerolone compound containing isoproterenol cyclopentamine and propylene glycol has a much longer duration of action which may exceed four to five hours so the dose interval should be prolonged or a cumulative drug effect will occur. Many physicians are not aware of the duration of action of most of the bronchodilator agents used, and may order IPPB bronchodilator therapy every four hours or more often. It is easy to see why such a dose regimen may lead to serious side effects including EKG abnormalities or myocardial infarction. Both supraventricular or ventricular arrhythmias occur frequently in respiratory failure, and electrocardiographic monitoring is essential.

Tolerance to these agents develops and response is frequently less than optimal in the presence of tissue acidosis or hypoxemia. This may cause the physician to increase the dose with resulting side effects. Finally, much attention has been directed recently toward the fact that both sympathomimetics and xanthines are effective in smaller doses when beta receptors in the lung have been "sensitized" with systemic corticosteroids. This drug interaction has been cited as the mechanism responsible for improvement following steroid administration in bronchitics who continue nebulized bronchodilator therapy.

Metered dose aerosols may be convenient for the patient but a breathless patient will invariably abuse the use of these devices, sometimes with disastrous results. Most metered aerosols deliver between 75-150  $\mu\text{g.}$  of sympathomimetic per spray, so dangerous overdosing is more common than ordinarily recognized. If this form of bronchodilator therapy is regularly employed, patients should be cautioned not to use the spray for more than eight to ten sprays (daily). The fluoroalkanes which serve as propellants in metered aerosols have recently been shown to be toxic to the myocardium of animals, including man.

There is no such thing as an average, ideal or usual dose of bronchodilator agent. Flow characteristics of individual nebulizers, the depth of inspiration, secretions, and the deranged architecture of the airways and parenchyma all influence response to therapy. What may be a suboptimal dose of bronchodilator for one patient may cause serious side effects in another. Nevertheless, bron-

chodilator therapy is effective in relieving distressing symptoms, but it is a form of therapy which must be carefully and individually tailored to meet the needs of the patient in a given clinical setting.

Routine bland aerosol therapy involving administration of saline or water by cool mist or jet nebulizer is of limited value in hydrating dense sputum. Most commercially available cool mist nebulizers and some heated nebulizers are woefully inadequate in changing the viscoelastic properties of sputum and the physician might be better advised to employ systemic hydration, a method sometimes forgotten. For heated mist therapy to be even partially effective it must be continuously administered for at least one to two hours.

Again, low-flow continuous nasal oxygen need not be interrupted for heated mist treatments in patients with respiratory failure. Heated mist should routinely be administered by compressed air rather than wall oxygen. Unfortunately, compressed air is not ordinarily available for mist treatments in most hospitals and in this circumstance it is wiser not to use heated mist if only an oxygen power source is available. This will prevent the patient from receiving an unnecessarily high concentration of oxygen with deleterious effects on the arterial blood gases. Heating elements commonly employed for heated mist therapy rarely heat above 110 F. and if high-flows of any dry gas (oxygen or air) are employed, the liquid output of the nebulizer will decline sharply as the solution cools.

Ultrasonic nebulization is more effective in depositing large volumes of water in both the large and small airways, but it should be used with caution, especially in patients with poor cough or in those patients with diminished ventilatory reserves (low vital capacity) as they may literally drown in their own secretions. Ultrasonic nebulization is best followed by chest physiotherapy at which time an ineffective cough can be augmented. Inhalation therapists, technicians, nurses and patient's families should and can be educated in these techniques. Heated mist and especially ultrasonic nebulization may cause significant bronchospasm, particularly of the small airways. Pretreatment with bronchodilator material may not be completely effective in preventing this complication and therapy must be discontinued. Prolonged, continuous exposure to ultrasonic nebulization in severe respiratory failure should be avoided. Most of our patients in this treatment category are usually receiving corticoids, and we

ordinarily delay bronchodilator treatments for 24 to 48 hours in an effort to sensitize the beta adrenergic receptors to insure effective bronchodilatation in doses not likely to cause serious side effects, nor bring about worsening of physiologic parameters.

A reasonable aerosol program for a patient in respiratory failure might include in addition to continuous low-flow oxygen, treatment with bronchodilator therapy followed by two to four hour treatment of either heated mist or by a 30 minute ultrasonic treatment. This, in turn, should be followed by chest physiotherapy to patient tolerance.

Acetylcysteine is a mucolytic agent which is said to rupture the sulfhydryl bonds of mucin and is of value in those patients with continued viscid secretions who have failed to respond satisfactorily to intensive bland ultrasonic therapy. It must be used in large quantities, 10 ml of a 20 per cent solution in a mainstream nebulizer, or 20 ml of a 10 per cent solution administered by ultrasonic nebulization. Its use cannot be recommended on a routine basis in respiratory failure and it should be avoided in asthmatics as it may cause worsening bronchospasm which is not reversed by pretreatment with a potent bronchodilator. Detergents, other mucolytic agents, steroids and antimicrobial aerosols have limited value in acute or chronic respiratory failure. Antimicrobials and corticosteroids, when indicated, are best given systemically. Wetting agents and pancreatic enzymes may be harmful as they theoretically might interfere with the stabilizing properties of lung surfactant. Humidification without concomitant mist therapy is of no value in sputum hydration.

Inhalation therapy equipment, including all aerosol devices, is subject to bacterial contamination and may serve as reservoirs of hospital-acquired gram-negative pneumonias. Large volume nebulizers, including ultrasonic, are the primary source of this contamination. Fortunately, most hospitals are aware of the potential role of inhalation therapy equipment in nosocomial and gram-negative pulmonary infections but no hospital can consider its decontamination program satisfactory unless it has a monitoring program and unless the more susceptible parts of equipment are changed and decontaminated at least every 24 hours.

### POSTURAL DRAINAGE

Postural drainage and other physical measures, including chest clapping and mobilization, are invaluable parts of the overall management of patients in respiratory failure. Unfortunately, more attention is paid to IPPB bronchodilator treat-



ments, and most inhalation therapists and nurses are completely unfamiliar with the specific techniques of chest physical therapy. Except for vigorous chest clapping and shaking in the upright position (which serves to move secretions from the periphery of the lung to larger bronchi from which they can be more easily expectorated), patients in acute respiratory failure do not accept more vigorous chest therapy. In a graduated program of respiratory care such as has been outlined, the physician needs to keep in mind what the patient will accept in terms of his comfort or discomfort and be mindful that these techniques require daily modification. For example, expansion of the lower chest and diaphragmatic breathing are difficult if not impossible to teach the acutely breathless patient, but rather, the physician might assist the patient in finding a position of comfort. Perhaps it may be as simple as sitting on a stool, leaning forward, straight back with the arms resting on the thighs. Sometimes patients prefer to lean forward from the hips with the upper chest and head supported on several pillows. Both of these positions favor chest clapping, shaking and cupping. While there is a specific drainage position for each bronchopulmonary segment, most patients in respiratory failure will respond favorably to a modified drainage program.

To drain the base of the left lung, have the patient turn into a right side-lying position, tip the bed into Trendelenburg and hold for 10 minutes. Do the same for the opposite base except have the patient in the left side-lying position. To drain the right middle lobe, have the patient in a less than left side-lying position but raise the hips with a pillow or with several folded sheets. Drain the lingula in the same manner. Each position should be maintained for 10-15 minutes. It may be necessary for the patient to sit up for more effective expectoration and sometimes mucus will not be expectorated until postural drainage has been completed. In order to increase the effectiveness of drainage, the patient should be taught to breathe in, and expand the area being drained, while on expiration the chest wall is rhythmically compressed, clapped or shaken. Some patients achieve a much better inspiratory capacity and are able to tolerate the head-down position better when a compressed air powered IPPB machine is used. With significant improvement, segmental postural drainage and breathing exercises become important parts of the ambulatory care program for patients with asthma, bronchitis and emphysema. It is important that drainage be carried out

on a regular basis and it is usually most effective on arising in the morning and at bedtime.

## CORTICOSTEROID THERAPY

Corticosteroid therapy has been repeatedly shown to be beneficial in patients with acute and chronic airways obstruction. The favorable effects have been described even in stable emphysema and previously attributed to the so-called anti-inflammatory effect, suppressing bronchial wall inflammation, and possibly suppressing unknown allergic factors. Unfortunately, physicians have been reluctant to use corticosteroids in the past because they feared the well documented effects of hyperadrenocorticism, including gastrointestinal bleeding. Too, several controlled studies of the use of corticosteroids in the treatment of pulmonary emphysema have shown that frequently subjective response outweighs objective changes. Although there may be no subjective change in the dynamic or static lung volumes after eight weeks of Prednisone therapy under controlled conditions, several investigators have described improvement in arterial blood gases and in the pulmonary diffusing capacity for carbon monoxide. Significant side effects of corticosteroid treatment such as increased susceptibility to infection, pituitary adrenal suppression, diabetes, and osteoporosis may be avoided by alternate-day Prednisone therapy. Indeed, patients on such a program have remarkably mild side effects.

The recent demonstration of the importance of the small airways in the pathogenesis of bronchitis and emphysema has led to renewed interest in the use of steroids in lung disease. It has been suggested that emphysema passes through a rather prolonged stage where disease and obstruction may smoulder for years in the small airways and that this inflammation and edema with obstruction might respond favorably to the systemic administration of cortisone. We feel that the short-term gain, using steroids in acute and chronic respiratory failure secondary to chronic obstructive lung disease, may well justify its use in respiratory failure. The degree of involvement of small airways is impossible to determine, and a steroid reversible component may be present. Certainly a trial of Prednisone can be justified in the presence of worsening arterial blood gases, continued bronchospasm, and in the face of impending external ventilatory support. Numerous retrospective studies have now shown that a trial of corticosteroids for less than one month carries little or no risk. Gastrointestinal bleeding is not related to past or present ulcer disease, and when matched controls

are compared, bleeding is not more common in steroid-treated patients. Reactivation of pulmonary tuberculosis is extremely rare, but we do not hesitate to use preventive chemoprophylaxis, even in the presence of a non-reactive tuberculin skin test. As the patient improves, the corticosteroid dose is reduced, and he is gradually shifted to an alternate-day program. Bronchodilator therapy frequently becomes more effective in smaller doses in a disease where tachycardia and coronary artery narrowing are prevalent. We have repeatedly demonstrated as have others, the combined effectiveness of low-dose, alternate-day steroid therapy when combined with less than the usual or even the recommended therapeutic dose of a nebulized sympathomimetic amine. Patients with atopy are frequently highly responsive to combination steroid-bronchodilator therapy.

Exercise training on a treadmill, stationary bicycle, or graded walking, while not associated with measurable improvement in pulmonary function is, however, frequently associated with subjective improvement in addition to increased maximal work load with significantly decreased heart rates. In exercise programs, low-flow oxygen supplementation may increase exercise tolerance and be a useful adjunct in patients unable to begin exercise programs while breathing room air. The time course of exercise training is slow, and many weeks may be required before benefit is realized.

★★★

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This study was supported by the Mississippi TB and Respiratory Disease Association (Mississippi Lung Association).

A selected bibliography, in addition to detailed instructions for postural drainage, is available on request from the authors.

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## AN AVID GOLFER

A golfer came home bone tired. His wife asked why. . . . "Oh, Charlie had a heart attack on the 2nd hole." "Oh, how terrible." "Yeah! Just imagine, I had to hit the ball . . . drag Charlie . . . hit the ball . . . drag Charlie, all 16 holes. . . ."

—*Hawaii Medical Journal*



# The Art and Practice of Medicine in The Supine Hypotension Syndrome With Case Report XVI of the Maternal Mortality Study

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ADEQUATE SYSTOLIC and diastolic blood pressure are the products of (among other things) at least three major factors: an effective pump, sufficient blood volume, and adequate peripheral resistance. All three must be present simultaneously. Conversely, a deficiency or inefficiency of any one of the three will result in a diminution in the blood pressure, circulation, and perfusion of organs and cells.

In the present instance as in most others, everyday kitchen or farm or home workshop experience is more than adequate to explain why a woman pregnant at term will often feel badly when lying on her back.

Consideration of a recirculating electric patio water fountain gives description and understanding. The pump (heart) propels water (blood) through the outflow pipe (artery) and causes the attractive spray (adequate blood pressure) if the nozzle (peripheral resistance) has a small opening (arteriolar tone) and the return pipe (vein) is under water and not obstructed by a rock (gravid uterus compressing the vena cava).

Since the vena cava traverses the retroperitoneal space in front of and slightly to the right of the lumbar vertebral bodies, it is vulnerable to obstruction by compression by the gravid uterus when the mother is supine. When such a situation occurs in the final days of pregnancy, the blood pressure falls because sufficient blood is prevented from getting back to the heart and thus can not be pumped into the aorta to maintain the necessary blood pressure and flow that supplies oxygen and nutrients to the vital centers and organs of the mother *and* the fetus.

The *mother* does not have to understand the process to know something is wrong. She feels weak, nauseated, short of breath, and has a sense

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*This is the case report of a 20-year-old female prima gravida who died while giving birth. The autopsy showed vascular congestion and edema of the lungs, liver, spleen, pancreas, adrenals and kidneys. The committee felt the case represented an example of the supine hypotension syndrome. The author gives a detailed explanation of this syndrome and how it should be handled.*

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of impending doom. She is restless and turns. When she is on her side, the uterus rolls off of the vena cava, the obstruction is relieved, the venous return increases, the cardiac output increases, the blood pressure comes up, adequate circulation returns, starving centers are oxygenated and nourished once again, and the patient returns to comfort and health.

She soon learns (though she may never become overtly conscious of it) that she should lie on her side. When her physician notices her on the examining table lying on her side as he enters the room (most patients are on their back), he should be suspicious that the location of this particular patient's vena cava is such, her uterus is contoured by the baby's prominences just so, and his weight sufficient that there is compressive obstruction of the vena cava. He should pursue this observation by asking her to lie on her back, pretending to examine her in that position. If after a few seconds the mother is restless and turns to her side, the suspicion is emphasized.

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## SUPINE HYPOTENSION / Caine

Routine inquiring as to the patient's ability/inability to sleep or lie on her back in the last two or three weeks of pregnancy will usually tip the physician off to *expect* the supine hypotension syndrome at the time of delivery.

Prenatal blood pressure determination with the patient on her back and found to be low which on turning to one side or the other is followed by the blood pressure returning to normal confirms the phenomenon.

### PATHOLOGIC PHYSIOLOGY

Since most parturient women are basically healthy specimens with efficient hearts and there is actually a compensatory increase in circulating blood volume due to intrauterine shunting, the factors of peripheral resistance and venous return play the major roles in this circumstance. For this reason blood transfusions and/or electrolyte infusion is not logical total treatment, a fact attested to by the slow or non-existent beneficial response. In addition, when the obstruction is relieved, the central gushing of (ineffective) intravascular priming may result in an overshoot—pulmonary edema and/or congestive heart failure.

In the fountain example, when the nozzle is opened widely (peripheral vasodilatation), the water squirts less high (blood pressure falls). In the present life situation certain drugs (anti-hypertensives, for example) lower the pressure by decreasing peripheral resistance through vasodilatation to a variable degree.

Most inhalation anesthetic drugs do the same (ether, fluothane, penthrane, trilene) in addition to decreasing the force of contraction of the heart (pump).

Regional anesthesia (spinal-saddle, and caudal-epidural) also dilate vessels and decrease peripheral resistance to a mild degree due to chemical sympathectomy.

So the combination of vena caval compression plus peripheral vasodilatation is synergistically detrimental.

To treat this syndrome with vasoconstrictors only is directing therapy mostly at a symptom and not at the main root cause. In addition, vasoconstriction of the uterine vessels further reduces the blood flow through an already poorly perfused uterus—further compromising the embarrassed fetus.

In the zoo fountain example, no amount of narrowing the nozzle orifice will produce a tall spire of water if the water line is kinked. Likewise treatment of the supine hypotension syndrome pharmacologically with vasopressors (even intravenous-

ly) is met with disappointment in effecting the desired rise in pressure and disappearance of the symptoms and signs of acute hypotension (apprehension, restlessness, fright, pallor, nausea, emesis, etc.) as long as the uterus obstructs the vena cava.

The rhythmic contraction of muscles, even at rest, aids venous return by propulsion of blood toward the heart. General anesthesia and especially regional anesthesia decrease this force.

The lift pump action of the alternate changes in intra-thoracic pressure during the inspiratory and expiratory phases of respiration is blunted by the increased abdominal contents that splint the diaphragm in the elevated position.

Thus, the supine hypotension syndrome is in actuality "bloodless hemorrhagic" shock, there being no visible or extra vascular blood loss. It is therefore best treated by the auto-transfusion that takes place when the obstruction to the vena cava is relieved.

Just as moving the automobile tire off of the lawn sprinkler hose will effect a simple, immediate, logical, rational, and satisfying restoration of the shower that is watering the grass—so getting the gravid uterus off of the vena cava will lead to a rise in blood pressure to near normal and a disappearance of the distressing symptoms that accompany this threat to the life of the mother and child.

### DOCTOR-PATIENT RELATIONSHIP

The time is well spent to routinely explain all these technical anatomical and physiological possibilities to each pregnant patient. Among the benefits are: (1) instilled confidence in her physician's mastery of the situation (not an inconsiderable consideration), (2) cooperation, (3) lack of panic due to ignorance, (4) gratitude for the physician's respecting the intelligence of the mother, etc.

Then when the syndrome does occur, the patient will often say "Doctor, you remember that explanation you gave me of pressure on the big vein? Well, you were right. I've got it!"

Later she says, "You know, Doctor, I would have been petrified when I felt that way if I hadn't been prepared by you to look for it and to understand what all was going on."

With all of the above physiological and pharmacological background, it is my opinion that administration of a vasopressor prior to block is not necessary—even, perhaps, not indicated since the phenomenon of compression will be partly masked or clouded.

There is more often than not an increased spi-



nal fluid pressure at term. For some reason this tends to make block drugs that are deposited into the subarachnoid cavity progress cephalad more rapidly and farther than in the non-pregnant state. Thus, I use  $\frac{1}{2}$  to  $\frac{2}{3}$  the usual dose of anesthetic drug (10 mg. tetracaine-Pontocaine for a Cesarean section against 16 mg. for a hysterectomy in the same patient). Likewise it is not necessary to tilt the head down for as long or as steeply when using the hyperbaric technique (Spinal fluid specific gravity is 1.003 to 1.006. Pontocaine in 5 per cent glucose is 1.027).

When there is supine hypotension at the time of delivery, there is therefore understandably very poor peripheral venous filling in the upper extremities making venipuncture difficult during the bedlam of the serious emergency. Therefore, routine institution of I.V. fluid administration through a large plastic cannula (at least a 16 Medicut) prior to production of anesthesia will preclude a mad scramble at the time of possible profound low blood pressure a few moments after induction of anesthesia.

In hemorrhagic shock ordinarily there is a tachycardia. But bradycardia is most often present in the supine hypotension syndrome, after subarachnoid block anesthesia. Premedication with atropine will help counteract that bradycardia that is produced by the partial paresis of the cardiac accelerator nerves that are sometimes in the canal as low as T-4, the upper fringe of the area of anesthesia.

#### IN PRACTICE

A base line pressure reading is determined with the patient supine, and prior to any anesthetic or obstetric intervention. If it is low, pressure is determined with the patient on her side.

I produce the subarachnoid block for Cesarean section with the patient in the left lateral decubitus position. Since I am right handed and the spinous processes project postero-caudad, the angle of insertion of the needle antero-cephalad is more natural than with the patient on her right side. In addition, and pertinent to the present discussion, the uterine tumor is displaced off the vena cava.

In the sitting position that some use for saddle block for vaginal delivery, the pressure from the intra-abdominal mass is exerted less against the spine than in the supine position, which the patient assumes shortly thereafter.

As soon as the anesthetic drugs have been injected, the patient is *rapidly* turned to her back and the head of the surgical table is lowered to approximately 30° Trendelenburg position. The patient's head is placed on a pillow so the chin is

flexed on the chest. This makes the lowest portion of the spinal canal at the vertebra prominens. Should the hyperbaric anesthetic solution inadvertently ascend cephalad higher than intended due to its unusually rapid progression in pregnancy at term, its ascent will still be arrested below the C-4 level from which the phrenic nerve that innervates the diaphragm emerges. Thus, although all the intercostal nerves may be undesirably paralyzed, the diaphragm will still be active, providing some respiratory exchange.

The potency of the anesthetic drug is dependent on its concentration. The injected bolus is quickly diluted. Thus profound (and therefore adequate) anesthesia is produced in the first very few seconds.

The level of hypesthesia (slightly less than usual sensitivity) is determined by pin prick. A level to the umbilicus (T-10) for vaginal delivery; and to T-8 (halfway between the xiphoid and umbilicus) for Cesarean section are adequate and desirable. The table is quickly levelled to stop the gravitational flow of the solution that is heavier than spinal fluid. Vide supra.

Anesthesia follows hypesthesia in five minutes or so. The incision may be made without pain by the time the patient is prepared and draped (10 minutes). Anesthesia to the xiphoid (T-6) is not excessive, but is the upper limit to which the heavy solution should be allowed to progress by gravity.

Attempts to rush these steps of procedure will bring distressing experiences of too high a level, inadequate anesthesia, pain, disappointment, disapproval, and a higher incidence of sharp tempers, coronary occlusion, and stroke in one or more of those present—patient, obstetrician, anesthesiologist.

Again—let me suggest that at each step of the way, what is *going* to be done and why, is told to the patient. Like "Mrs. Jones, Miss Smith is going to clean off your back with a cold antiseptic—I mean real cold!" "Now I'm going to wipe your back off." "You'll feel a little needle stick and sting like you felt when I started that drip in your arm a while ago" (I always deaden the site of venipuncture with a "mosquito bite" of local anesthetic drug). Patients in the know are better behaved, more cooperative, more appreciative, and get along better.

Tell the patient you are going to prick her with a pin point before proceeding to do so to determine the level of hypesthesia, etc.

O<sub>2</sub> is given by mask and anesthesia machine at high flow from the time she turns on her back until *at least* delivery.

## SUPINE HYPOTENSION / Caine

Blood pressure is determined every 15 to 30 seconds. If no profound fall is noted, be happy and continue taking readings. Mention to the patient that the blood pressure is OK, so far. (She'll smile understandingly.)

If the pressure begins to fall (say from 120 systolic to 100), tell her "Your pressure is down a little so I'm going to push that lump off the big vein."

Then push the uterus to the left and hold it there. Continue blood pressure determinations. If this repositioning is sufficient to effect relief of the vena caval blockage, no more treatment is necessary. A word to this effect to the patient is appreciated.

Should the blood pressure continue to fall, tell her you are going to tilt her hip and do so. A rolled up sheet making a lump grapefruit size will give 30-40° angulation. Manually displace the uterus also. Sometimes the right knee must be bent and moved forward and to the left.

The patient is kept in this tilted position throughout prep and drape and Cesarean section through delivery of the fetus. Then (and only then) may the prop under the hip be removed to allow the obstetrician to "close up" in a more comfortable and convenient stance.

Ordinarily, no vasopressor; no transfusion; no pint to quart infusion push are needed: and no panic; no confused pandemonium are created.

The mother is far more helpful, calm, and grateful if she is told *ahead of time* what is going to happen and what she will experience. "Mrs. Jones, your blood pressure has fallen and you will probably feel nauseated for a short while." "Yes, Doctor, you are so right. I do." Then, "Now, ma'am, I've relieved the obstruction, your pressure is back up, and you should feel much better." "Right" (smile). "Thank you."

Rarely is it necessary to do more than the above. But on occasion the pressure fails to return toward normal even with the patient lying all the way on her side (90°). When this occurs, I try turning the patient on her right side with the idea that *her* vena cava is positioned further left than usual. On occasion this maneuver relieves the hypotension.

Rarer still, 5 mg. ephedrine (0.1 cc of 50 mg. ampoule) intravenously injected into the cannula adapter and flushed in with 50 to 200 cc of I.V. solution is resorted to. If this effects a rise in pressure, fine. The hesitance in giving a vasopressor at the outset is that since it is not curative of the pathophysiology, its use except as a later resort

measure is almost routinely followed by all parameters working at the same time and the pressure goes over 200. Thus the patient goes from one extreme to the other and all the others present go from crisis to crisis.

In a rare instance none of these procedures is effective. Perhaps the reason is that unlikely patient with a decreased blood volume at term; or more likely an anatomic combination of either vertebral body prominence, or uterine fibroid, infant shoulder or occiput, etc., that is just so situated as to occlude the vena cava.

In this circumstance, immediate, expeditious Cesarean section is performed. The niceties of 10 minute scrub, meticulous draping, minute hemostasis, etc. are by-passed and the uterus emptied forthwith. When done, mother and baby are delivered from impending doom and the anoxic consequences to each are obviated. Then the refinements of definitive surgery may be resumed.

All of the above presupposes a healthy mother with no more additional burden than normal pregnancy at term. Patients with complications such as placenta previa with hemorrhage and shock, etc. are best made insensitive to pain by general anesthesia with a drug that maintains peripheral vascular tone (say, cyclopropane).

This dissertation on the suspicion of, confrontation with, and handling of the supine hypotension syndrome is made available because, and as it is because, the Committee on Maternal and Child Care of the Mississippi State Medical Association has so determined from its review of certain cases of maternal and/or infant deaths due to anemic asphyxia of the supine hypotension syndrome in Mississippi over the last several years.

### CASE NO. 595-12542-70

This 20-year-old prima gravida had an expected date of confinement of Aug. 22, 1969. Her last menstrual period was Nov. 15, 1968. She was Rh positive. The lab values were Hbg. 10 gm and serology was negative. She had made five antepartal visits to her physician from July through September. The membranes ruptured spontaneously five hours prior to delivery and she was in labor for six hours. The presentation was vertex-occiput-anterior. The patient was given "heavy" nupercaine subarachnoid saddle block for vaginal delivery. "The mother died five minutes later." No mention was made in the protocol of height or extent of anesthesia in dermatomes. There was no fever, hemorrhage or edema. A living female baby with "loud precordial murmur" was born *after* the mother died. The infant was breathing poorly and slow to respond. There



are no blood pressure recordings in the scanty chart. Resuscitative efforts by the "cardiac team" were of no avail.

The autopsy showed vascular congestion and edema of the lungs, liver, spleen, pancreas, adrenals, and kidneys. "Many of the blood cells have a sickle form indicating the probability of a sickle cell trait." "Special strains for mucus reveal a few small positive globules within the pulmonary capillaries indicating probable embolism of amniotic fluid."

The autopsy diagnosis was (1) amniotic fluid embolism and (2) sickle cell trait.

After consideration of all the circumstances and events surrounding this report, it is the considered opinion of the committee that: (1) The amniotic fluid emboli found at post are no more than common at most uneventful deliveries.

(2) The vascular congestion of the organs is a routine agonal finding.

(3) This case represents a straightforward example of the supine hypotension syndrome inadequately diagnosed, understood, and treated.

(4) There is at least one other explanation of this mortality: total spinal anesthesia; with apnea, hypotension, asphyxia, and death. This complication also is preventable and curable. "Artificial respiration would have saved my Clementine."

#### HISTORICAL NOTE

Mengert first fully described this syndrome in 1953 (in a patient observed in September of 1950). Stead in October of 1952 commented the origin was venacaval compression. McRoberts in 1951 presented six cases. ★★★

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The author gratefully acknowledges the assistance of John R. Bise, M.D., Susan Wakefield, and Carolyn Sellers.

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## DRIVER'S ED

"Did any of you get a chance to practice what you've learned?" the driver ed. teacher asked his class.

"I did, sir," responded a pretty little junior. "You know those signs up town that say One Hour Parking? Well, yesterday, I did it in 55 minutes!"



# Profiles of Adolescents Admitted to Mississippi State Hospital in 1972 for Drug Problems

JERRY M. ROSS, M.D.  
Whitfield, Mississippi

INCREASED INSTANCE of drug use among youth has caused great concern at the Mississippi State Hospital at Whitfield. There has been a significant increase in admission for drug use and abuse. The admission for primary drug use increased fourfold in the past two years. Drug and alcohol abuse have long been a problem in adults admitted to this hospital. In adults the most popular drug for abuse is the current popular minor tranquilizer. In youth, it seems to be common to abuse marijuana, amphetamines and barbiturates.

Youth aged 16 to 21 are admitted to the hospital on court order, signature of two physicians, or the chancery clerk and two physicians' signatures.

In 1972, 365 young people were admitted. Forty-seven of these were given a diagnosis of drug abuse as either the primary or secondary diagnosis. The hospital stay of this group varied but average was about two weeks. A significant number were using the admission to manipulate the environment and manage to cut the stay from a therapeutic length of three to four weeks. The ages varied from 16 to 20 with the greatest number being in the 19 and 20 age group. Thirty-seven of the 47 were male. The greatest number, 41, were white.

Suicide is a common precipitant for a mental hospital admission and of this group, 12 had made an attempt. It is difficult to determine how serious each attempt is in the mind of the patient. In this group, experience leads one to first find the person or situation toward which the suicide attempt is directed. Suicide attempts seem to be used more often to change the situation into one more favorable for the patient than the angry act toward an individual or self.

Only four of this group had armed service experience. Three had been discharged for various reasons and one was currently in the National Guard.

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*The author gives a detailed profile of the adolescents admitted to the Mississippi State Hospital at Whitfield during 1972 for drug problems. He discusses types of drugs used, educational level of the youth, marital status, history of arrests, and work history as well as general characteristics to be found in young drug users.*

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None of our group showed withdrawal to opiate-like substances and the only barbiturate type withdrawal or C.N.S. depressant withdrawal was slight and was managed by 30 mgs. of Phenobarbital four times daily for about five days.

The types of drug used varied with those available. We have noticed a pattern over the years; it seems that youthful drug abusers tend to use what's available. This certainly seems to occur in the small towns, especially until the supply develops where they have a choice of drugs.

The educational level in the group was low. Only six had completed high school or started college. Twenty-three of the group had a ninth grade or less educational level. The educational attainment ties closely to the work experience. It seems that school like work requires time, effort, and initiative that addicted persons cannot or are not willing to put forth.

Only six of our sample were married. I would postulate that both their age and their self-centeredness play a part in this finding. I am not at all sure how their peers view them as marriage prospects. If one chooses to believe their sexual his-

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Presented before the Section on Family Practice, Mississippi State Medical Association, Biloxi, May 2, 1973.

## ADOLESCENTS AND DRUGS / Ross

tories, they have no difficulty in finding bedmates. We tend to believe this because we have problems with peers of the opposite sex visiting and bringing drugs to patients.

These patients had 36 arrests, seven of which were drug related. Six of our patients told of stealing to support a habit. A large number of our patients were selling drugs and 15 admitted a history of selling drugs. Information regarding drug arrests was pieced together from personal history, family history, and police information. The drug merchant pattern seems to be a young man who lives away from home, doesn't work regularly, his parents don't give him money, he doesn't live with a girl and he frequently makes trips to a larger city, that are more or less unexplained.

Most of these admissions had used drugs two years or more (29). They may have started on one drug and changed. We couldn't find any evidence that they progressed from marijuana to hard drugs.

Three of the patients had a trade; five had worked regularly. The others did not work at all or worked two to three months per year.

Physically, it seems hepatitis is the greatest danger. Four of our group had clinical hepatitis; one had diabetes; one received a pelvic fracture in an auto accident. There were several cases of general debilitation and a few cases of gonorrhea. One of the hepatitis cases developed acute yellow atrophy. We have since started getting admission SGOT's and find a significant number of abnormalities in clinically negative cases. It has been a surprise that gonorrhea, syphilis, physical illness, and pregnancy are not found more often. Pregnancy does result, but these girls abort. I'm not sure how these abortions come about since they are reluctant to discuss it. Factual history isn't often present. We do see "bad trips" and one case of psychosis was attributed to drugs. There very well may have been more since the differentiation of a drug psychosis is so difficult. In general, I'd say that drug induced psychosis is suspected more often than it occurs. One of our cases culminated in death from liver failure.

I will attempt to give a description of the patients by giving their major personality traits. The majority of our patients were immature and unstable with psychopathic and hypomanic features. They could be expected to quickly become angry and belligerent when crossed or thwarted in their goal of personal pleasure. Interpersonal relationships are superficial and problems with authority

figures are frequent. Despite their attempts to appear moralistic, behavior usually tends to be amoral. Superficially, they appear fun, eager, outgoing, and likeable, but in reality they are irritable, hostile, and self-centered. They usually have strong dependency needs present, and they use sex to gain this dependency. This usually brings about sexual acting out on a meaningless interpersonal level. There may or may not be homosexual concerns but the likelihood of forming a meaningful heterosexual relationship is guarded. The anxiety index is usually low since these persons generally act out any conflicts. Ego strengths vary, but generally tend to be below average.

In general, these people act without thinking, are markedly self-centered, selfish, and avoid close interpersonal contacts.

## CLASSIFICATION OF USERS

Proskauer and Rolland propose a classification of drug users that is divided into three types. One is the experimental drug users. This category consists of a large segment of the youthful population who take drugs at one time or another under the influence of peer pressures, deviant feelings toward adult authority, curiosity, or a desire for new sources of ascetic and essential experience. They emphasized that these young people have no compelling need for a drug experience and cannot be said to have a drug problem. They further state that the healthy adolescent eventually finds the sense of passive enslavement to the drug insufferable and his progressive wish for development, active mastery identity, and object relationship more urgent and satisfying than the drug's effect. Two is the depressive drug user. This group comprises a vast number of young people who are seeking adaptive and defensive solutions primary to feelings of emptiness, loneliness, helplessness, hopelessness, and worthlessness through drug experiences. He points out that this group is especially vulnerable and drugs seem to be an attractive way of avoiding pain and bypassing the active work needed to establish more mature object relations. His third classification is characterological drug users. This group is said to be a much smaller group of young people who were exposed in early life to deprivation, inconsistency, and rejection. These experiences have resulted in major ego deficits. He further states about characterological drug users that these young people were in serious difficulty in childhood well before they started on drugs and usually experienced deprivation in early infancy, multiple losses of significant



persons during childhood and hostile dependent relationships to their mothers. As adolescents and adults they must contend with low tolerance, with frustration, poor impulse control, a relatively poor capacity to bear anxiety and depression, trouble in relating to others in a mutual way and unreliable reality testing especially under internal or external stresses.

It would seem to me that our study seemed predominantly weighted with the characterological drug users where the experimenters or depressive type patients were in the minority.

Siegel states that drug taking behavior among tramps begins as extensions of similar habits and life styles that were begun at home. He indicated that the prognosis beyond detoxification may hinge above all on each patient's fundamental psychological resources. Such assessments reveal normative patterns of adjustment in a minority of cases. He also says that rarely do patients demonstrate substantial personality strengths with histories reflecting stable interpersonal relationships and achievements.

It seems that some of the wisest and most factual information that I am aware of on drug abuse comes from Dr. Dana Farnsworth, the con-

sultant in psychiatry at Harvard University and the vice chairman of the National Commission on Marijuana and Drug Abuse. Dr. Farnsworth in his keynote address given at the 79th session of the annual conference of National Organizations in Miami in 1972 said as follows: "The public must learn to view the drug problem in perspective, as a part of a much larger complex of social concerns. People have tended to see drug use as a source of other difficulties. The seeming alienation of the young, a confusion of values, crime, racial conflict, and social dissension. The public tends to regard drugs as a cause rather than an aspect of these problems."

"We now have no drug education program in this country, or elsewhere, that is sufficiently effective to warrant our recommending it to all other concerned communities."

"The only effective control will be in the form of self-control by young people."

Miss. State Hospital (39193)

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## SIGN OF THE TIMES

Some mothers who married their childhood sweethearts now have daughters who will probably marry their college roommates.

# Radiologic Seminar CXXXII: The Barium Enema

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McComb, Mississippi

AN ESTIMATED two to three million barium enemas were done in 1963, and this number has surely increased significantly since that time.

The barium enema is a very informative procedure, and the record of safety is quite good. It is probably the most effective overall method of diagnosing carcinoma of the colon as well as most other colonic lesions; however, rectal lesions are best diagnosed by direct visualization by sigmoidoscopy, and a negative barium enema does not rule out rectal disturbances. The barium enema is never a substitute for rectal examination or sigmoidoscopy and should be preceded by such an examination before a barium enema is even requested.

Although the barium enema is an excellent diagnostic method, it is not as simple as is thought and, all too often, it is limited, not by the elusiveness of the colon lesion, but by technical and human error. Improper cleansing of the colon is a common problem and a frequent source of diagnostic error. Fecal material retained in the colon not only may obscure the lesion, but also lowers the radiologist's index of suspicion. Failure of information to be relayed to the radiologist, such as a previously difficult delivery with rectal lacerations, has caused serious complications.

Most radiologists consider the following procedure to be adequate for barium enema preparation:

1. Low residue diet for 24 hours.
2. Two ounces of castor oil on the night preceding the examination.
3. Enemas on the morning of the examination, preferably administered by a trained aide.

It should be noted here that the practice of giving soap suds enemas should be discontinued. Soap is a strong chemical cleansing agent which works well on fabrics and human skin, but has no place on the mucous membranes inside the body. It is also no better than water or saline solution.

In the barium filled phase of the examination x-rays should be obtained at a K V sufficient to penetrate the barium (generally 100-120 K V). The double contrast technique is not only advantageous for small polypoid lesions, but it also provides a "second look" and a further means of confirming a suspected lesion.

There are many confirmed reports of iatrogenic incidents resulting from enemas, such as perforation by the enema tip, laceration from the presence of barium enema balloon, rupture of the colon from hydrostatic pressure, water intoxication, liver necrosis following a tannic acid and barium mixture, etc.

The complications of barium enemas are mostly due to perforation of the colonic wall, and the mortality from these is high. They may lead to barium granuloma formation, or, even worse, to venous extravasation of barium, which is a highly lethal complication. One of the causes of colon perforation is abrasion of the anterior rectal wall by rectal catheters. In this regard it should be stressed that technicians should be taught to perform this gently and stop if resistance is encountered. A flexible, non-abrasive catheter should be used. No doubt many barium enemas would not be feasible without the balloon catheter, which is a useful adjunct, but it is subject to certain limitations and should not be used in patients with known rectal disease, particularly inflammatory diseases. It should never be used in persons with colostomies or in infants and young children. The balloon should never be placed beyond the distensible rectal area and should never be distended beyond the minimal necessary to get the proper examination. Another cause of perforation is high intraluminal pressure. A maximum of 24 inches and a customary pressure of 18 inches is used; however, one should use the least head of pressure which is effective.

Most radiologists feel that a barium enema should not be done immediately following sigmoidoscopy. This almost always results in a poorer procedure than if the barium enema were done on a different day. Most feel that if the in-

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Sponsored by the Mississippi Radiological Society.  
From the Department of Radiology, Southwest Mississippi Regional Medical Center, McComb, Miss.





*Figures 1 and 2. Perforation of colon with barium extravasation.*

dication is enough to put the patient through the preparation and procedure, it is important to get the best examination possible. There is also the danger of perforation, particularly if a biopsy has been performed. Separation of the two examinations should contribute materially to avoiding a completely unnecessary hazard and getting a better examination.

Complications of barium enemas could be reduced substantially by a clearer appreciation by radiologists and their fellow referring physicians of the causes. The radiologic detectability of colon lesions by barium enema could and should be improved. The responsibility rests, not only with radiologists and their colleagues; but also with administrators who, in many instances, determine the quality of radiologic equipment, personnel supplied to radiology, and the conditions of the examination.

#### CASE REPORT

This 80-year-old white female came in with apparent obstruction in the colon. During the barium enema, multiple diverticuli were seen in the sigmoid and a napkin-ring lesion was noted in

the descending colon. When it became obvious that a perforation had occurred, the examination was discontinued and it was assumed that the carcinoma had perforated. However, at surgery the carcinoma was intact and a diverticulum had perforated. The patient died three days later.

★★★

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# The President Speaking

## "Thoughts on Abortion"

ARTHUR A. DERRICK, JR., M.D.

Durant, Mississippi

I WONDER if you are as confused as I am on the issue of abortion. Hopefully, you are not.

Having just experienced once again the tedious necessity of informing a frantic mother that her 14-year-old daughter was indeed pregnant, my mind, my judgment, my responsibility, my code of ethics, and, yes, my heart were touched and tested once more.

Did I do the right thing? I surely hope so. But. . .

The rationalizations swirl in a cluttered brain. "I will not give to a woman a pessary to produce abortion." "I will follow that system of regimen which according to my ability and judgment I consider for the benefit of my patients." "I will abstain from whatever is deleterious and mischievous." Those darned Greeks again! With their young male paramours and their orgies, and they put this on us. But the 4th century B.C. That's a long time. Hippocratic or hypocritic?

How do you equate her pleading silent eyes with a supreme court decision? "A pregnant woman does not have an absolute constitutional right to an abortion on demand. . . ." The mother's set accusing wounded face, her own backseat escapades long-forgotten. . . . "The decision to abort rests with the physician."

Dispatch her to the sterile strangeness of an abortion clinic (New York City's fastest-growing business—business?). She looks like Rebecca of Sunnybrook Farm, but her pelvis is ripe with the anachronistic hormonal surge. "Abortion is to be placed on the same footing with other surgical procedures."

The suction curette poised to remove the detritus of spent lust. "The court avoided the necessity to grapple with the definition of life." Detritus? Are spermatozoa now transistorized, and ova plastic baubles?

Professor John Money at Hopkins states that pregnancy and childbirth are treated as a disease and abortion is surgery rather than a psychic event and a persistent memory.

Did I do the right thing? I will always wonder.

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## Physicians' Standards Review Organization

The much cussed and discussed medical review outlined in the PSRO mechanism encompassed in Public Law 92-603 is to be implemented in every state beginning Jan. 1, 1974. Have you read the law? If you have not, read it today. The information gained therefrom will be valuable to you during the next few years of your practice. Copies of the law may be obtained from our Mississippi State Medical Association.

If you have read the law, have you sacrificed sufficient time from your busy practice to study and digest its contents with an unbiased eye? The essence of the legislation is that you should document that which you are doing all the time—delivering quality medical care to your patients!

Before we develop any qualms that might magnify the already existing prejudices that have arisen in the wake of other injudicious government health programs implemented without medical input and under the control of third parties, let us take a careful look at the PSRO statute and attempt to analyze some of its pertinent points.

First, we must recognize that Public Law 92-603 is the law of the land. During the annual session of the Mississippi State Medical Association in May 1973, the House of Delegates handed down a mandate to the Mississippi Foundation for Medical Care to implement PSRO in Mississippi. Plans for organization in this regard are far advanced. On Aug. 7, 1973, a conference was held between representatives of the Department of Health, Education, and Welfare and representatives of the Mississippi Foundation for Medical Care, Mississippi State Medical Association and other interested parties, relative to the designation of certain PSRO areas in Mississippi. At the present, we have good reason to believe that Mississippi will be designated as a statewide

PSRO. An advantage is that we can all work together under the same roof. It is also possible that in the light of the advanced knowledge and capability in this field gained from our experience with EMCRO that the Mississippi PSRO may be declared a pilot program. An additional advantage is that we can have an impact on the whole PSRO mechanism.

Next, let us review the intent of the law and some of the functions of the PSRO mechanism:

(1) The PSRO will monitor inpatient services as to medical necessity. This is not likely to be a serious problem as every reputable physician would certainly not only feel offended but wounded to find documented evidence leaning against him in this regard. However, there may be a few that have not given sufficient thought to the question and have not taken the time to record and thus document that which he has done for his patients and the reasons for doing so. Good records are paramount and serve as supporting evidence of medical service being medically necessary.

(2) The PSRO will monitor and support the delivery of quality medical care. The second principle function of the PSRO is to monitor quality medical services for institutional care. We will not discuss the definition of quality medical care as it is a variable factor and eludes definition. Rapid changes in the field of medicine demand that the norms and standards used to measure the level of medical care be updated constantly to keep abreast of medical progress. It has been generally stated that quality medical care is now being delivered by at least 95 per cent of the physicians of Mississippi. This most likely is true, but we have no documentary records to prove this to the satisfaction of the taxpayer who is paying for the Medicare and Medicaid programs—and by

## EDITORIALS / Continued

the way, this includes us! Every conscientious physician feels that he is now delivering quality medical care to his patients at least within his own knowledge. All of us can benefit from our own medical review.

The basic unit of the PSRO, and this is clearly stated in the law, begins at the grass root levels—the utilization review committee of each hospital staff. The utilization review committee and the medical audit committee should work hand in hand to organize a review mechanism and develop standards and norms as related to levels of quality medical care. In discharging these duties both committees will find the EMCRO mechanism of review, as well as the suggested norms and standards with related diagnosis, highly valuable as a resource.

(3) The PSRO will determine the appropriateness of medical care. That relates to asking whether the patient you admitted to the hospital could have been given medical care at home just as well, or at a less expensive facility available in your community. Are you admitting patients with minor ailments instead of administering necessary medical care and sending them home? Are you discharging your patients from the hospital, when in your own judgment they have received necessary medical care, to allow continued convalescence at home or in a less expensive facility? Or do you find it much easier to be influenced by the socioeconomics of the patient and the pleadings of the family to prolong hospitalization, when it is not medically necessary? These are questions that confront all of us. They can be dealt with fairly within the bounds of quality medical care and the PSRO mechanism. It may require a bit more time on the part of the physician and a clear and to the point explanation to the patient and family, using the support of the utilization committee/PSRO mechanism to shoulder a part of the responsibility.

Now that we have discussed some of the main functions of the PSRO, let us scrutinize some of the points of interest that may be to the advantage of the medical profession. It is conceded by many careful observers within and without the medical profession that there are several good points in the PSRO statute that favor the physician in private practice. It would seem that the greatest advantage dwells in the fact that it returns the control of the private practice of medicine to its appropriate place—the practicing physician and the medical profession.

For many decades the fight for the control of

the private practice of medicine has been going on in a subtle sort of a way, among factions and groups outside of the medical profession. During the past 15 years the threat has become so obvious and serious that the hard working, dedicated physician, mentally and physically absorbed in the greatest era of scientific and medical achievement that the world has ever known, has finally become alarmed. With continued encroachment from all sides by labor, the legal profession, news media, third party insurance carriers and the federal government, the plight of the physician has certainly become precarious. With PSRO functioning at the local level under the guidance of the utilization review committee and the cooperation of other members of the medical staff, the control of the practice of medicine can again be in the hands of the physician. The regional and state level portion of the review mechanism serves only as a support and appellate mechanism for the utilization review committee in carrying out its functions.

Another advantage of the PSRO both for the medical profession and others should come from the educational value of the data gathered and used. The physician learns by having his shortcomings pointed out to him so that he might cor-

BUT MY FEW DOLLARS  
WON'T MAKE ANY  
DIFFERENCE



Thankfully not everybody says that. We know different. Your dues, added to mine, and to everybody else's dues, can make a difference. But, maybe you would rather go to work for the government?

If not join us in 1973 . . . and bring along a friend.





rect his mistakes and upgrade medical care to his patients. Those outside of the profession have the advantage of a vast reservoir of data reflecting the true picture and verified facts in the delivery of quality medical care. The so-called "experts" testifying before committees at the national level, exerting influence on legislation frequently reflecting a personal and ideological interest, will no longer be in vogue. The PSRO mechanism should in a few years have compiled a data bank of information of unprecedented size, available to the physician for the purpose of education, documentation, and research in the delivery of medical care.

As interpreted by the elected leaders of our association and the Mississippi Foundation for Medical Care, the PSRO is supportive and educational to the profession and not punitive or contrary to the best interest of the private practice of medicine. It is the pledged duty of the officials of these two organizations to organize and support an effective review system within the bounds of improving the private practice of medicine in the state of Mississippi and at the same time in no way ignoring human needs or medical reality.

If PSRO implementation places the private practicing physician in an untenable position and the mechanism evolves to a level incompatible with the private practice of medicine, then the opposition and fighting should begin. To oppose in its entirety that which is yet to be implemented and tried is to reverse the order of progress—particularly with the strong points in the law favoring the medical profession. The better approach, it would seem, would be to diligently and conscientiously implement the law and at the end of the two year probation period strive to separate and eliminate the bad points from the good, retaining the latter and replacing the former with improvements gained from experience.

The Mississippi Foundation for Medical Care is moving forward to perfect the framework of organization for implementation of the PSRO law. A state level physician professional review committee representing all areas of the state has been appointed. It is anticipated that appropriate and operational products of the MSMA/EMCRO program will be used to build the PSRO mechanism. We believe that we are far ahead of other state medical associations in this regard.

The third parties as well as many of our allied medical friends outside the medical profession are crying for a part or all of the action as they recognize the opportunity and authority of the agency that implements PSRO. The opportunity is here if we have the foresight to take it and make it

work. We have two years to make good. Let's get to work!

J. T. DAVIS, M.D., Corinth, Miss.  
President, Miss. Foundation  
for Medical Care  
President-elect, MSMA

## REPORT OF THE DELEGATES TO AMA

*New York Annual Convention.* The AMA House of Delegates confronted with the largest business agenda in the association's history acted on a wide range of issues during the 122nd Annual Convention (June 24-28, 1973) which affect physicians in their relationships with government, medical schools and hospitals, and with the public.

The issues ranged from PSRO's and wage-price controls to institutional licensure and the need for more primary care physicians. Meeting for a total of 18 hours and 51 minutes, the House acted on 84 reports and 179 resolutions for a total of 263 items of business.

As might be expected, PSRO was one of the major subjects before the AMA House. Two reports from the Board of Trustees outlining successful AMA efforts in providing physician input into the drawing up of PSRO regulations by the government, and in other areas, were filed by the House. In addition, two resolutions bearing on PSRO's were adopted. One resolution, initiated by California and amended, reads as follows:

*Resolved,* That the Secretary of Health, Education and Welfare be informed that the only organizations which can give qualified peer review for physicians' services to the patient, physician, government and taxpayer are those composed of practicing physicians, whether these are state or local groups; and be it further

*Resolved,* That since many of these practicing physician groups are functioning successfully, with multiple approaches, as peer review organizations, the regulations be so written to authorize these existing peer groups to continue their review as PSRO's or as functioning units of PSRO's, thus partially alleviating the unnecessary and costly implementation of new agencies as PSRO's.

The second resolution adopted was a substitute in response to a number of resolutions introduced, ranging from those calling for the AMA to go on record in opposition to PSRO's, to one urging the association to seek repeal of the law. The substitute resolution, which conforms to PSRO

**DELEGATES REPORT / Continued**  
policy approved by the House at the 1972 convention, reads:

*Resolved*, That although it is recognized that repeal or modification of PSRO legislation ultimately may be required to preserve high quality of patient care, the American Medical Association should oppose any facets of this current legislation which act to the deterioration of quality care, publicize such deleterious facets, and place highest priority on developing and pursuing appropriate amendments to preserve high quality of patient care.

Six resolutions were introduced protesting discrimination against physicians under the government's Economic Stabilization Program and the following substitute resolution was adopted by the House:

*Resolved*, That the American Medical Association continue to work by all lawful and practicable means to assure non-discriminatory treatment for physicians under present and future Economic Stabilization Programs.

In other actions affecting the relationship of physicians with government (and third parties), the House:

—Encouraged continued efforts to develop a uniform claim form for insurance claims.

—Supported the on-going efforts to educate physicians, private insurance plans and government agencies as to the advantages of adopting the 3rd edition of Current Procedural Terminology to identify and report services provided by physicians.

—And directed the Council on Medical Service to study the problems presented by "prospective admission" of hospital patients under Medicare and Medicaid, "retrospective denial" of benefits and report its findings and recommendations at the 1973 Clinical Meeting at Anaheim, California.

On the subject of institutional licensure, the House adopted a report of the Board which calls for the AMA to oppose the extension of institutional licensure in lieu of individual professional licensure to physicians and nurses. Testimony before the reference committee, including representatives of the nursing profession, was unanimously in support of opposition to institutional licensure.

Lengthy debate centered on a resolution from Illinois which protested unilateral changes in medical staff bylaws by hospital boards of trustees that usurp the prerogatives of hospital medical staffs. Similar situations were reported in Arizona and South Dakota. A motion from the floor to refer the resolutions was defeated. After consider-

able discussion, delegates approved the following substitute resolution:

*Resolved*, That the American Medical Association declares that any proposal or arrangement between a hospital board of trustees and its medical staff that conflicts with the AMA principles of medical ethics is improper; and be it further

*Resolved*, That unilateral changes in medical staff bylaws by hospital boards of trustees is also improper; and be it further

*Resolved*, That the AMA suggest that the following preamble be included in all medical staff bylaws:

The hospital and the medical staff have a duty to cooperate in their mutual responsibility of assuring the high quality of patient care standards within the hospital. Only physicians can practice medicine under the laws of the state. In those areas in which medical judgment and the evaluation of professional competence are involved, the hospital has a duty to rely upon the judgments and recommendations of the medical staff, to cooperate and to provide needed assistance with full understanding that the primary responsibility is that of the medical staff.

The House approved a report of the Board of Trustees concerning physician distribution by specialties which has important implications for the medical profession and for the public. The report outlines the increase in number of medical schools, the increase in approved residencies and internships, and the increased number of allied health and continuing medical education programs. The report, as amended by the House, contained two important recommendations. They are:

The AMA should adopt immediately, publicize widely and promote vigorously a goal to have at least 50 per cent of all medical graduates enter residency training in the primary care specialties in the coming years.

The need for numbers and type of physicians should be monitored continuously and reassessed periodically in regular reports to the House of Delegates.

On the subject of physicians' unions, the House adopted a resolution presented by the New York delegation which reaffirms the tradition of the medical profession of not withholding medical services (withholding services is a practice of most unions), or performing any act interfering with public welfare. The House also approved a Board of Trustee report which opposes unionism among self-employed physicians. The report also



recognizes that physicians in employment situations need assistance and support, and encourages the Board of Trustees to maintain its interest and concern for these physicians. The report also affirms the no-withholding of services principle.

The House took several actions in regard to medical malpractice, including approval of a report from the Board of Trustees which outlines the proposed formation of a Medical Liability Commission to represent health care providers in dealing with medical malpractice problems. The proposed commission was outlined by a planning committee consisting of representatives of the AMA, AHA, American College of Surgeons, American College of Physicians and four specialty societies. An organizing meeting for the proposed commission will be held in Chicago in September.

After considerable discussion, the House voted a change in the AMA Constitution and Bylaws to provide a seat on the Council on Medical Services and the Council on Medical Education for a representative from the intern-resident members of the AMA.

A great deal of discussion also took place pertaining to the separation of the business and scientific meetings of the AMA. No final decision was made and the meeting will continue as combined meetings through 1976 as contracts have been formalized to that date.

In other action the House instructed the Council on Constitution and Bylaws to prepare for the 1973 clinical session (Anaheim, California, December 1973) a measure that will allow the House to vote on whether Trustees shall serve a maximum of two, three year terms. The present maximum is three, three year terms.

The House adopted several recommendations on the subjects of membership certification and dues. They were:

Physicians shall become members of the AMA upon certification by state medical societies rather than by AMA receipt of dues.

The delinquency date for remittance of AMA dues is changed from June 1 to April 30 of each year, and the requirement that members who have been dropped for non-payment of dues must pay one year's past dues is eliminated.

The criteria for exemption from AMA dues shall be consistent with exemption from state medical society dues, except that members reaching their 70th birthday may apply directly to the AMA for Active Dues Exempt Membership status.

Elimination of the requirement that AMA membership be limited to those physicians in military service whose tour of duty is two years or

more. Younger physicians serving two years or less in the military or the U. S. Public Health Service will be eligible for AMA membership, and county and state medical societies are encouraged to adopt this procedure.

In other actions, the House:

—Adopted a substitute resolution recommending that the AMA urge the enforcement of strict penalties for the use of firearms in the commission of a crime.

—Tabled a resolution urging AMA support for the open sale of condoms to minors.

—Referred to the Council on Mental Health a resolution urging AMA support of a model penal code decriminalizing sexual behavior between consenting adults, and AMA support to end legal and employment discrimination against homosexuals. The council was instructed to report back at the 1973 clinical meeting.

—Affirmed the traditional favorable attitude of the medical profession toward pregnancy and motherhood, and encouraged the development of counselling programs that will offer constructive help to prospective mothers in coping with the stresses of pregnancy.

—Reaffirmed the AMA abortion policy which states "Abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in accredited hospitals acting only after consultation with two other physicians, and in conformance with standards of good medical practice and the Medical Practice Act of his state. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of good medical judgment or personally held moral principles."

Officers elected were Russell B. Roth, Pennsylvania, installed as President; Malcolm C. Todd, California, President-elect; E. Bryce Robinson, Jr., Alabama, Vice President; Tom E. Nesbitt, Tennessee, Speaker of the House; William Y. Rial, Pennsylvania, Vice Speaker of the House; John H. Budd, Ohio, Richard E. Palmer, Virginia, James H. Sammons, Texas, and Kenneth C. Sawyer, Colorado, AMA Board of Trustees; George H. Mills, Hawaii, Judicial Council; John H. Burkhart, Tennessee, Council on Constitution and Bylaws; J. Jerome Wildgen, Montana, Russell S. Fisher, Maryland, Louis Burgher, Minnesota (resident-intern member), Council on Medical Education; Hector W. Benoit, Jr., Missouri, Drew M. Peterson, Utah, Daniel Ostergaard, Minnesota (resident-intern member), Council on Medical Service.

(This report was prepared by G. Swink Hicks, M.D., of Natchez, Delegate to AMA.)



# Woman's Auxiliary to the Mississippi State Medical Association

## PLEASE DON'T FORGET . . .

*Please don't forget* to include your wife's state and national Auxiliary *dues* when you are billed for your own by MSMA this fall! These annual dues are only \$7.00 and benefit everyone. They pay for:

*MD's Wife*, national magazine

*Distaff*, state newsletter

Operational expenses (headquarters office, convention, conferences and workshops)

Printing and distribution of Package Programs, other program materials and health education aids

Loans to medical students and nurses

Scholarships

Contributions to AMA-ERF

*Thank you again* for your continued support in helping us to finance the *Distaff*, our state newsletter!

*We would also like you to know* that we are aiming high in *AMA-ERF Contributions* this year under the enthusiastic leadership of State Chairman, Mrs. Edward Hill of Hollandale. Our goal is \$10.00 per capita, which, if reached, would mean a gift of over \$10,000 from Woman's Auxiliary to MSMA. Here's to success!

JANE PRESTON

(Mrs. William H. Preston, Jr.)

President, Woman's Auxiliary





### Book Reviews

**Scintigraphy of the Pancreas.** By Carlo Prior, M.D., and Umberto Valente, M.D. 135 pages with 134 figure illustrations. Padua, Italy: Piccin Editore, 1971. \$10.00.

The authors in the clinical surgery department at Siena University and the departments of surgical pathology and clinical surgery at Genoa University in conjunction with the Institute for the Study and Treatment of Pancreatic Disease present in brief, concise and readable form a detailed method of pancreatic scintigraphy using a primary isotope for pancreatic imaging—Sc-75 (Selenomethionine) and then an auxillary tracer which is selectively absorbed only in the liver. Imaging is carried out by a retro-linear scanner utilizing an electronic subtraction circuit which automatically permits one to obliterate the liver shadow from the pancreatic scintigraph and obtain separate scans of the liver and the pancreas.

Excellent concise information is given on the historical aspects of pancreatic scintigraphy and the development of Se-75 with complete studies of the physical, chemical, biological and physiological and toxicological properties of Se-75.

An adequate discussion of the principal of electronic subtraction or obliteration of the hepatic image is included, as well as the general mathematics of the electronics, collimator, and scanning speed and densities.

One of the better features of the book is the concise assessment of the role of the pancreatic scan in respect to multiple other clinical and radiologic tests to evaluate the pancreas.

The valuable feature of this publication is the series of scintiscans of the pancreas in four major disease categories and excellent interpretative analysis and rules for diagnosis in the categories of acute pancreatitis, chronic pancreatitis, pseudo cysts and tumors, and cancer of the pancreas either primary or secondary by invasion from some adjacent structure.

It is of interest that the authors state adequate surgical and pathological material to correlate in the last three categories and readily admit that they had very little correlative material in the first category, namely that of acute pancreatitis but

give no figures to illustrate this. Also in respect to their very excellent approaches to diagnoses of the various lesions in the above four categories they give no figures as to their preoperative diagnoses correlating with pathologic findings.

CARL R. HALE, M.D.  
Hattiesburg, Miss.

**Annual Review of Allergy—1972.** Edited by Claude Albee Frazier, M.D. 328 pages with illustrations. Flushing, N. Y.: Medical Examination Publishing Company, 1973. \$12.00.

Twenty-eight contributors have reviewed the literature in the field of allergy and each has written an individual chapter in his field. The paper back book covers all aspects of allergic disease in great depth.

It would be of most benefit to those who regularly treat allergic diseases, but all physicians who wish to expand their knowledge would find this volume helpful.

I was particularly impressed with Chapter IV, "Asthma in Adults," in which an excellent differential diagnosis is discussed and all the treatment modalities are reviewed.

Chapter VI gives a good review of pulmonary function studies under varying asthmatic conditions.

Chapter VII, "Corticosteroids in Asthma," by Dr. Helen Morris of CARH in Denver is an excellent review of steroid therapy and is a must for the physician who will treat asthmatics on a long term basis with corticosteroids.

There are many new drugs undergoing clinical trials which do show promise as being selective Beta adrenergic stimulators. These are discussed in Chapter XV, "New Drugs in Treatment of Allergy."

In summary this book is a review of the recent literature of allergy and is to be a yearly production. The only fault is that the print is small. It would serve as an excellent reference for those whose primary interest is the treatment of allergic diseases.

ELLIS M. MOFFITT, M.D.  
Jackson, Miss.



## LETTERS

SIRS: Recently, there have been many inquiries concerning the availability and use of Rocky Mountain Spotted Fever Vaccine.<sup>4</sup> Current RMSF vaccines are prepared from yolk sacs of infected embryonated chicken eggs and have not been evaluated adequately in controlled trials. Cohen<sup>1</sup> has shown that complement fixing (CF) antibody levels develop in 22 per cent of recipients after a single dose of vaccine and in 63 per cent of vaccines after three doses. Booster doses six months after primary series did not routinely result in a rise in titers. There is no convincing evidence that CF antibodies are protective in humans. Cases of RMSF have occurred in personnel who have received the recommended doses of RMSF vaccine. The vaccine may only modify the disease rather than prevent it. Because of the questionable efficacy of current RMSF vaccines and the low risk of contracting RMSF even in endemic areas, vaccine is recommended only for the following special situations:<sup>3</sup>

(1) laboratory personnel working with *Rickettsia rickettsii* and

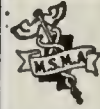
(2) persons whose occupations result in repeated exposures to ticks in endemic areas.

The average child or citizen with recreational or sporadic exposure should avoid tick-infested areas as much as possible, wear protective clothing, and remove ticks promptly. Forceps should be used for tick removal whenever possible. Alertness on the part of both patients and physicians will speed early diagnosis and treatment of clinical cases of Rocky Mountain Spotted Fever with tetracycline or chloramphenicol before complications develop. Analysis of fatal cases in recent years indicates that the most important factor is not an unusually fulminant course but rather delay in initiating therapy.


DURWARD BLAKEY, M.D., Director  
Division of Preventable Disease Control  
State Board of Health


## REFERENCES

1. Proc. Soc. Exp. Biol. Med. 128:191-195, 1968.
2. JAMA 211, March 30, 1970.
3. Supplement, MMWR, Vol. 21, No. 25
4. S. Car. Epi. Notes, June 15, 1973.



## DEATHS

 CARR, ISAAC PRICE, Clarksdale. (E-RET). M.D., Tulane University School of Medicine, New Orleans, La., 1913; interned Vicksburg State Charity Hospital, Vicksburg, Miss., one year; member of Fifty Year Club of MSMA; Emeritus member of MSMA & AMA; died Aug. 6, 1973, age 88.

 HASSELTINE, LEE LUTHER, Corinth. M.D., Louisiana State University School of Medicine, New Orleans, La., 1935; interned Charity Hospital, New Orleans, La., one year; died Aug. 31, 1973, age 65.



## NEW MEMBERS

DAVIS, DONALD SMITH, Meridian. Born Iuka, Miss., Jan. 11, 1937; M.D., University of Mississippi School of Medicine, 1966; interned Chatham County Memorial Hospital, Savannah, Ga., one year; residency in otolaryngology, University Medical Center, Jackson, Miss., 1969-72; elected by East Mississippi Medical Society.

DRAPER, KENNETH DEAN, Iuka. Born Batesville, Miss., Nov. 27, 1935; M.D., University of Tennessee School of Medicine, 1960; interned Duval Medical Center, Jacksonville, Fla., one year; elected by Northeast Mississippi Medical Society.

HEMNESS, EDWIN M., Clarksdale. Born Fargo, N. Dak., Feb. 19, 1924; M.D., University of Louisville School of Medicine, Louisville, Ky., 1953; interned Naval Hospital, Bremerton, Wash., one year; residency in orthopaedic surgery, Naval Hospital, Bethesda, Md., 1956-59; residency in orthopaedic surgery, Wilmington, Del., Jan. 1959-Dec. 1959; elected by Clarksdale and Six Counties Medical Society.

THOMAS, JAMES BOYCE, Tupelo. Born Cartersville, Ga., April 8, 1943; M.D., University of Virginia School of Medicine, Charlottesville, Va., 1969; interned Charity Hospital, New Orleans, La., one year; pediatric residency, same, 1970-72; elected by Northeast Mississippi Medical Society.



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ROBITUSSIN A-C <sup>®</sup>	●	●	●			
ROBITUSSIN-DM <sup>®</sup>	●	●		●		●
ROBITUSSIN-PE <sup>®</sup>	●				●	●
COUGH CALMERS <sup>®</sup>	■	■		■		■

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## POSTGRADUATE CALENDAR

### THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

*Oct. 1-5, 1973*

#### ELECTROCARDIOGRAPHY INTENSIVE COURSE

University Medical Center, Jackson  
October 1-5, 1973, beginning at 9:00 a.m.

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

#### Coordinator:

Thomas M. Blake, M.D., professor of medicine, The University of Mississippi School of Medicine

Selected for their immediate applicability, topics in this one-week course will be supplemented by use of electrocardiograms, slides and other visual aids. Participants will interpret electrocardiograms and join in conferences.

*Oct. 15-19, 1973*

#### PEDIATRICS INTENSIVE COURSE

University Medical Center, Jackson  
October 15-19, 1973, beginning at 8:00 a.m.

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

#### Coordinators:

J. M. Montalvo, M.D., associate professor of pediatrics, The University of Mississippi School of Medicine

Nell J. Ryan, M.D., associate professor of pediatrics, The University of Mississippi School of Medicine

Participants will join in ward and intake rounds, refresh their skills in such areas as scalp vein techniques, use of the respirator, resuscitator, nebulizer and humidifier, and attend lectures on fluids, hematology, cardiology, immunizations, allergies, pediatric emergencies, pediatric surgery, renal problems and the care of the newborn.

*Oct. 22-26, 1973*

#### NEPHROLOGY INTENSIVE COURSE

University Medical Center, Jackson  
October 22-26, 1973, beginning at 8:00 a.m.

Sponsored by the University of Mississippi School of Medicine with support from the Mississippi Regional Medical Program

#### Coordinator:

John D. Bower, M.D., associate professor of medicine and director of the artificial kidney unit, The University of Mississippi School of Medicine

In this clinically oriented course, emphasis will be placed on reversible and treatable forms of kidney disease. The management of acute kidney failure and control of reversible features of chronic kidney disease will be presented in depth.

*Oct. 29-Nov. 2, 1973*

#### HEMATOLOGY INTENSIVE COURSE

University Medical Center, Jackson

Oct. 29-31, Nov. 1, 2, 1973, beginning at 8 a.m.

Sponsored by the University of Mississippi School of Medicine, with the support of the Mississippi Regional Medical Program

#### Coordinator:

Francis S. Morrison, M.D., associate professor of medicine and instructor, department of clinical laboratory sciences, the University of Mississippi School of Medicine

Recent advances in oncology, as well as the basics of diagnosis and up-to-date therapy will be presented in this course. Supportive management will emphasize component hemotherapy and particular problems of infection in immunosuppressed patients.

All of the intensive courses are offered through the Mississippi Postgraduate Institute in the Medical Sciences, with partial support from the Mississippi Regional Medical Program, The Kidney Foundation of Mississippi, Inc., the Lilly Research Laboratories, the Bristol Laboratories, and private donations. The courses are open to all Mississippi physicians. A registration fee of \$100.00 is charged.

### SEMINARS

*Oct. 16, 1973*

#### PULMONARY SEMINAR

University Medical Center, Jackson

October 16, 1973, beginning at 8:30 a.m.

Sponsored by the Mississippi Lung Association, the Mississippi Thoracic Society and the University of Mississippi School of Medicine

#### Coordinator:

Joe R. Norman, M.D., professor of medicine, director, division of pulmonary diseases and Mississippi Lung Association Christmas Seal Professor of Respiratory Diseases

This seminar will be concerned with the abnormal chest x-ray and diagnostic approaches.



Some of the topics to be discussed are sputum collection, fiberoptic bronchoscopy, the asymptomatic pulmonary nodule. The day will conclude with the annual meeting of the Mississippi Thoracic Society.

#### FUTURE CALENDAR

*Oct. 1-5*

ELECTROCARDIOGRAPHY INTENSIVE COURSE

*Oct. 15-19*

PEDIATRICS COURSE

*Oct. 16*

PULMONARY SEMINAR

*Oct. 22-26*

NEPHROLOGY INTENSIVE COURSE

*Oct. 29-Nov. 2*

HEMATOLOGY INTENSIVE COURSE

*Nov. 5-9*

UROLOGY INTENSIVE COURSE

*Nov. 12-16*

CARDIOLOGY INTENSIVE COURSE

*Nov. 12-16*

NEUROLOGY AND NEUROSURGERY INTENSIVE COURSE

*Nov. 28*

HYPERTENSIVE SEMINAR

*May 6-9, 1974*

MISSISSIPPI STATE MEDICAL ASSOCIATION,  
BILOXI

## Medico-Legal Briefs

### PHYSICIAN DENIED STAFF PRIVILEGES BY PRIVATE HOSPITAL

A hospital created by private persons as a profit-making corporation and solely controlled by private parties without intervention of public officials was held by a Florida appellate court to be a private hospital and could deny staff membership to a physician without a hearing and without informing the physician of the reasons for denial.

The physician brought action against the hospital, challenging its right to deny him staff membership. The trial court rendered summary judgment for the hospital, holding that it was a private facility and could deny staff membership without a hearing or the necessity of informing him of its reasons.

On appeal, the issue was whether the hospital

was a private institution. There was no dispute that the hospital was a private corporation for profit under state laws. Funds for its initial construction came entirely from private donations. The corporation was controlled by a board of directors composed of private physicians. There were no officers or employees of any federal, state, county, or municipal government on the board.

Hospital operating expenses did not directly come from any governmental entity. Although about 50 per cent of the patients were recipients of Medicare benefits, such benefits were paid through an intermediary—Blue Cross-Blue Shield.

The city did enter into a contract to give the hospital certain rights-of-way so that it could expand. There was a provision in the agreement whereby the property would revert to the city if construction of the additional facilities was not commenced in three years. The hospital maintained an emergency room that was open to the general public.

The physician contended that the hospital was a public or quasi-public facility, which could not deny him admission to practice at its discretion. He cited three reasons that he felt showed the public or quasi-public nature of the hospital: it expanded on land given to it by the city, with a deed containing a reverter clause; it existed on federal funds; and it was created to serve the public.

In a previous, almost identical, case, the Florida Supreme Court defined a private hospital as one founded and maintained by private persons or by a corporation, with the state or municipality having no voice in its management or formation or rules for its government. Thus, the appellate court said, the hospital met the definition of a private hospital.

As to the physician's contention that the hospital was public or quasi-public because of Medicare benefits and because of land donated by the city for its expansion, the court did not agree with his conclusion as a matter of law. The court pointed out that the Medicare program was not a direct subsidy to the hospital and that if a hospital were public because of Medicare coverage of its patients, all hospitals in the country would have to be considered public.

The court further pointed out that donation of land by the city did not in and of itself establish the hospital as public or quasi-public as there was no element of governmental control. Holding that the hospital was private, the court affirmed the judgment of the lower court.—*Monyek v. Parkway General Hospital, Inc.*, 273 So.2d 430 (Fla. Dist. Ct. of Appl., Feb 21, 1973)

## Medical Series Debuts on PBS-TV

"The Killers"—five hour-and-a-half medical documentaries—will be presented over the 237 interconnected Public Broadcasting Service stations across the country each month through March starting Nov. 19. The series is made possible by a grant from the Bristol-Myers Company, a multinational diversified manufacturer and marketer of products for health, personal care and the home, as part of a long-range program of corporate responsibility.

"The Killers" is designed to inform the public about methods of prevention, early detection and treatment of the five medical conditions that accounted for 75.7 per cent of deaths—1½ million—in the United States last year: Heart Disease, Inborn Genetic Defects, Pulmonary Disease, Trauma, and Cancer.

To increase the effectiveness of the series, local PBS stations will use the shows as springboards for community action. Working with local offices of national health organizations, community medical personnel and other interested citizens, many of the local stations are planning programming tied into the national series, as well as community follow-up activities such as lectures, workshops, demonstrations and informal clinics.

Control of editorial content of the series lies solely with WNET/13 Science Program Group, headed by Emmy and Peabody Award winner David Prowitt. Working with the group is an advisory board of 23 representatives of the health and medical professions selected by the group.

The programs will be presented across the country every fourth Monday evening. The schedule is: "Heart Disease," Nov. 19; "Inborn Genetic Defects," Dec. 17; "Pulmonary Disease," Jan. 14; "Trauma," Feb. 11; and "Cancer," Mar. 11.

Mississippi stations scheduled to carry the programs are WMAA (Channel 29) in Jackson, WMAB (Channel 2) in State College, WMAU (Channel 17) in Bude, WMAO (Channel 23) in Greenwood, WMAI (Channel 19) in Biloxi, WMAV (Channel 18) in Oxford, and WMAW (Channel 14) in Meridian.

Among the many participants in the "Community Outreach" programs are the AMA, American Cancer Society, American College of Surgeons, American Heart Association and National Genetics Foundation.

For more information on community programs, write Miraed Peake, J. Walter Thompson, 420 Lexington Ave., New York, N. Y. 10017.

# Rondomycin® (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopical discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, "Rondomycin" (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q i d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of "Rondomycin" (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** "Rondomycin" (methacycline HCl): 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



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CRANBURY, NEW JERSEY 08512





## PERSONALS

JAMES ARENS and WALTER TREADWELL of Jackson and UMC attended the Tri-State Respiratory Therapy conference in Biloxi in August.

LOREN BRELAND of Crystal Springs is serving as 1973 campaign chairman for the Mississippi Division of the American Cancer Society.

RONALD BROWN has associated with GERALD WESSLER for the practice of urology at 1118 Broad Avenue in Gulfport.

RONALD T. BRUNY has associated with MAX A. CURRY for the practice of pediatrics at Coastal Medical Center, Gateway Executive Park, Biloxi.

DONALD COOK and JOHN W. ROBINSON of Meridian announce the removal of their offices to the newly constructed Bone and Joint Clinic at 5002 Highway 39 North.

JOHN DIPLACIDO announces the opening of his office for the practice of obstetrics and gynecology at Doctors Park, 105 Hillcrest Drive in Houston.

THOMAS SENTER GLASGOW has joined the staff of the Doctors Clinic in Grenada for the family practice of medicine.

SIDNEY O. GRAVES of Natchez has been elected treasurer of the Jefferson Davis Hospital Board.

HAROLD K. HUDSON has associated with BROWN ROBERTSON for the practice of ear, nose and throat and facial plastic surgery at 808 Garfield in Tupelo.

HERBERT G. LANGFORD of Jackson and UMC attended a Hypertension Detection and Followup Program steering committee meeting in Warrenton, Va.

WAYNE T. LAMAR announces the opening of his office for the practice of orthopaedic surgery at 2168 South Lamar Boulevard in Oxford.

JAMES S. MCILWAIN announces his association with W. J. PATTERSON at the Clinton Family Clinic, 650 Highway 80 West in Clinton.

JERRY P. MOORE has joined the staff of the Rush Medical Group in Meridian. Dr. Moore is a board certified pathologist.

L. B. MORRIS of Macon was honored for his 50 years in the practice of medicine in that community with a reception at Pineview Country Club. He was presented two plaques.

JOE NORMAN of Jackson and UMC was guest speaker at a medical staff meeting at St. Joseph's Hospital in Meridian. Dr. Norman also spoke on nursing care of the emphysematous patient to an in-service education meeting of nurses at Howard Memorial Hospital in Gulfport.

JAMES S. POOLE, formerly of Centreville, has opened his office in the Gloster Clinic for the family practice of medicine in Gloster.

GERALD M. RANKIN has associated with the Street Clinic in Vicksburg for the practice of obstetrics and gynecology.

ROGER H. REED has associated with RAY H. STEWART at 233 Courthouse Road in Gulfport for the practice of general medicine. Dr. Reed is a 1969 graduate of UMC.

ANTONIO M. RUBIO has opened his office for the practice of psychiatry at St. Joseph's Hospital in Meridian.

SHELBY SMITH, TOM CAREY and BERT BRADFORD of McComb announce that their Children's Clinic, Ltd., is now located at 210 North Front Street.

RALPH SNEED of Jackson is currently serving as president of the Louisiana-Mississippi Ophthalmological and Otolaryngological Society.

JAMES P. SPELL of Jackson is currently serving as chief of staff of Doctors Hospital in Jackson.

JAMES R. TODD, JR., has joined the medical practice of FRANK E. JONES at the Fairview Clinic, 500 Katie Avenue, in the Professional Plaza of Hattiesburg.

VIRGINIA TOLBERT is currently serving as mayor of Ruleville.

W. BOYCE WHITE of Laurel has assumed the duties of Coordinator of Medical Services at Ellisville State School at Ellisville.

EARL WHITWELL of Tupelo was guest speaker at a meeting of the District 25 Mississippi Nurses Association. Dr. Whitwell, an orthopaedic surgeon, discussed total hip replacement.

# Gantanol® (sulfamethoxazole) and the

## 0.1 M.I.C. for three hours

Similar elongations  
occur regardless of  
antibacterial used.

## 1.0 M.I.C. for three hours

Similar midcell  
defects seen with  
increased antibac-  
terial concentrations.

## 10 M.I.C. for three hours

Similar spheroplast-  
like forms appear  
with high  
concentrations of  
the antibacterials.



E. coli + sulfamethoxazole



E. coli + tetracycline

## The Scanning Electron Microscope (SEM) reveals the effect

**The *in vitro* experiment.** These SEM photomicrographs were taken as part of a study exploring the effects of various antibacterials with different modes of action on the surface morphology of bacteria. The scanning electron microscope was used because of its ability to show three-dimensional views of organisms, enabling better definition and appreciation of surface morphology.

For this portion of the experiment, *E. coli* were exposed to the following agents: sulfamethoxazole, a chemical drug which acts by interference with para-

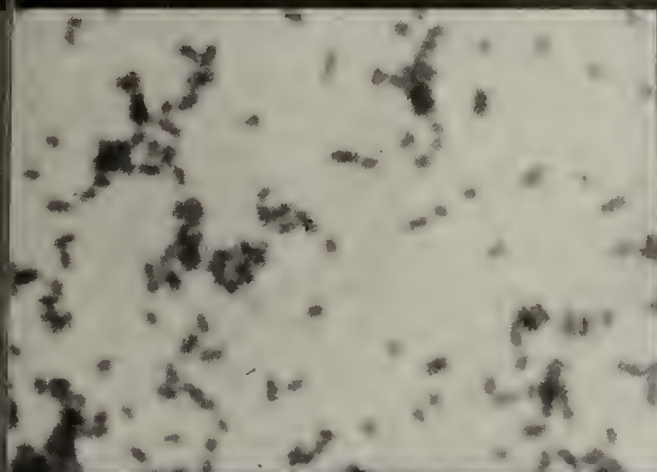
aminobenzoic acid utilization; tetracycline, which interferes with intracellular protein synthesis; and cephalothin and ampicillin, which are cell-wall-active drugs.

Strains of *E. coli*, each susceptible to the respective antibacterials, were exposed for 15, 30, 60, 120 and 180 minutes and 18 hours to several concentrations of each agent.

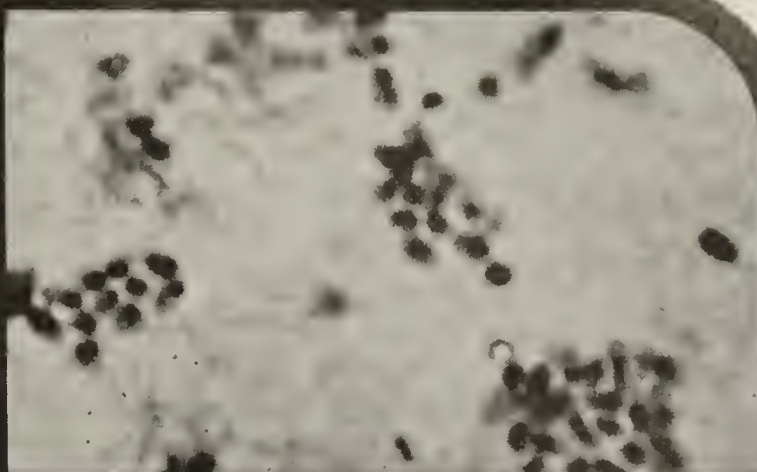
Following the 180-minute or three-hour exposures to the antibacterials at 0.1 M.I.C., 1.0 M.I.C. and 10 M.I.C., photoscans of the *E. coli* were taken. As shown above, regardless of the antibacterial agent used or its mode of action, the changes in surface morphology were remarkably similar... elongation at low drug concentrations, midcell defects at higher



# Clinical practice



*Enterobacter* sp.—Gram stain showing characteristic gram-negative rod



*Proteus mirabilis*—Flagella stain

## ■ Your option: tablets or suspension

Gantanol Tablets or the pleasant-tasting, cherry-flavored Suspension can provide dependable antibacterial activity to control susceptible nonobstructed cystitis and pyelonephritis. Symptomatic improvement usually may be expected to begin within 24 to 48 hours. Usual precautions with sulfonamide therapy should be observed, including adequate fluid intake. Gantanol is generally well tolerated, with relative freedom from complications; the most common side effects are nausea, vomiting and diarrhea. Frequent c.b.c.'s and urinalyses with microscopic examination are recommended during therapy.

\*Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

In nonobstructed cystitis due to susceptible organisms

# Gantanol<sup>®</sup> B.I.D. (sulfamethoxazole) Basic therapy

binemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

**Dosage:** Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

*Usual adult dosage:* 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

*Usual child's dosage:* 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

**Supplied:** Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



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## AMA Sponsors Alcohol Abuse Conference

Physicians from throughout the nation will participate in an American Medical Association-sponsored conference on medical complications of alcohol abuse Oct. 11-12 in Washington, D. C. at the Washington Hilton Hotel.

The two-day conference will be directed to physicians on diagnosis, management, treatment, rehabilitation and community resources for the alcoholic person.

"We hope to interest many more physicians in the problems of alcohol abuse," said Dr. Herbert Raskin of Southfield, Mich., chairman of the AMA's Committee on Alcoholism and Drug Dependence.

"We believe this conference will be of considerable educational significance and help to physicians as they treat and counsel their patients," Dr. Raskin said.

The conference will be co-sponsored by the Veterans Administration, the National Institute on Alcohol Abuse and Alcoholism and the National Council on Alcoholism. The program is being coordinated by Dr. William M. Lukash, White House physician.

Physicians attending the conference will receive 13 hours of continuing education credits toward the AMA Physician's Recognition Award program, and 13 hours of elective credits in the continuing education program of the American Academy of Family Practice.

Conference speakers will cover such topics as how to diagnose alcoholism, how to identify the potential alcoholic early, current approaches to treatment, biochemical features of alcohol in man, direct poisonous effects of alcohol, cause of death in alcoholics, management of acute medical emergency in alcohol abuse, skin and blood problems, nutritional problems and management of infection in alcoholics.

The final afternoon session will center on development of treatment plans and on appropriate use of medications. Treatment programs will be discussed in the context of family therapy, group therapy, the place of clergymen, community social agencies and the role of self-help agencies such as Alcoholics Anonymous.

The conference will coincide with Drug Abuse Prevention Week, proclaimed by the White House

for the week of Oct. 7-13.

In its published statement on "Alcohol and Society," the AMA Committee on Alcoholism and Drug Dependence concludes:

"Although a small quantity of alcohol can serve as a relaxant, further consumption, often under the guise of social drinking, can have adverse physical and psychological consequences.

"Impaired decision-making ability and reduced perceptual acumen are frequently the immediate results of intoxication; and drug dependence, as well as physical and psychological debilitation, are possible long-range results of consistent alcohol abuse."

Further information on the conference is available from the Department of Mental Health, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.



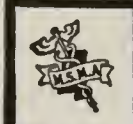
### How can he get to the top when he can't even get to the elevator?

Help create an environment that's barrier-free for the handicapped. Write to the President's Committee on Employment of the Handicapped, Washington, D.C. 20210.

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# MSMA Board of Trustees Handled Full Agenda at August Meeting

Sponsorship of a practice management workshop for new physicians, referrals from the recent MSMA 105th Annual Session, activities of the Mississippi Foundation for Medical Care, and an AMA Delegates' Report were among items of business coming before the Board of Trustees at its regular summer meeting on Aug. 16-17, 1973.

The Board approved joint sponsorship with the AMA of a practice management workshop for new physicians to be held in Jackson this fall. The two day workshop will feature a program on management and legal considerations for the physician entering private practice conducted by nationally recognized professional consultants.

Referrals from the House of Delegates concerned organization of the Board of Trustees, legislation, and an association sponsored program to certify in-state continuing medical education programs for physicians.

Appointment of an *ad hoc* committee to study organization of the Board of Trustees was announced by the association's president, Dr. Arthur A. Derrick, and consists of the following MSMA members: Drs. John M. McRae, Laurel; Ralph L. Brock, McComb; C. D. Taylor, Pass Christian; Frank H. Tucker, Jr., Meridian; John B. Howell, Canton; J. Manning Hudson, Jackson; William L. Weems, Jackson; Whitman B. Johnson, Jr., Clarksdale; and Lee H. Rogers, Tupelo.

The committee will consider referrals from the House of Delegates dealing with realignment of MSMA trustee districts, terms of office of trustees,

and composition of the Board of Trustees.

The association's delegates to the AMA presented a report on the June meeting of the AMA House of Delegates. The Board received the report for information and directed that it be published in an early issue of the *Journal MSMA*.

During the two day meeting the Board of Trustees met with other directors of the Mississippi Foundation for Medical Care and received reports from the foundation's committees on Professional Fees and Professional Review Activities. The former committee reviewed plans to conclude its survey of MFMC members' professional fees and to meet with representatives of various specialty groups in Mississippi. The latter committee reviewed organizational activities to implement PSRO in Mississippi.

In other business, the Board reviewed planning by the Council on Scientific Assembly for the 106th Annual Session and recommended that junior and senior medical student officers be invited to attend meetings of the association's councils on Legislation and Long Range Planning. The Board also acted to broaden its liaison committee with the Mississippi Hospital Association by placing the chairmen of the association's councils on legislation and medical education on the MSMA-MHA committee which formerly included the president, president-elect and chairman of the Council on Medical Service.

The Board scheduled its next meeting for Dec. 19-20, 1973, in Jackson.

# Recommendations<sup>†</sup> on Combination Live Virus Vaccines

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## American Academy of Pediatrics

### Committee on Infectious Diseases

In the September 15, 1971 AAP Newsletter sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

## United States Public Health Service

### Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."

<sup>†</sup>For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.





## Dr. Tatum Is Cardiology Fellow

A Mississippi doctor has been designated as a Fellow of the American College of Cardiology (ACC), the national organization representing specialists in cardiovascular diseases. He is among a group of 60 specialists admitted in the first half of 1973 to the medical specialty society's highest membership category.

Dr. Patrick H. Lehan of Jackson, ACC Governor for the state of Mississippi, indicated that the new Fellow is Dr. Frederick E. Tatum of Hattiesburg.

Dr. Tatum, as well as the other new ACC Fellows, has fulfilled stringent membership requirements based on years of practice and specialty certification. This effort, according to Dr. Lehan, culminates in his being considered by colleagues in his community as a specialist or consultant in cardiovascular diseases.

## Developmental Disabilities Directory Completed

A directory of services for the developmentally disabled in Mississippi has been completed and is being distributed by the Mississippi Interagency Commission.

The directory provides a listing of programs by county and mental health-mental retardation region as well as listing state programs and special education classes in the public schools. The directory will be updated periodically to insure that an accurate listing of DD programs is available.

The information contained in the directory was collected by the Mississippi Association for Retarded Children with the cooperation of United Cerebral Palsy of Mississippi, Inc., and the Mississippi Council on Epilepsy. The project was partially supported by a Developmental Disabilities grant through the Mississippi Interagency Commission.

## Woman's Auxiliary 1973-74 Officers Meet



*The 1973-74 officers of the Woman's Auxiliary to the Mississippi State Medical Association are from left, seated, Mrs. Dan Reikes of Hattiesburg, first vice president, and Mrs. W. H. Preston, Jr., of Booneville, president. Standing from left are Mrs. Henry H. Webb of Jackson, treasurer; Mrs. Jack Stokes of Pontotoc, corresponding secretary and convention chairman; Mrs. Jim C. Barnett, Jr., of Brookhaven, second vice president; Mrs. W. A. Brown, Jr., of Mathiston, recording secretary; and Mrs. Louis Lehmann of Natchez, parliamentarian.*

## SMA Continuing Ed Program Accredited

The Southern Medical Association (SMA) continuing education program has been granted full approval and accreditation by the Council on Medical Education of the American Medical Association (AMA). The announcement was made by Robert F. Butts, executive director of SMA.

As part of its continuing education program, SMA holds a scientific meeting annually to help keep physicians abreast of the latest medical advances. The 67th Annual Scientific Meeting will be held Nov. 11-14 in San Antonio, Tex. It will include a variety of scientific and medical sessions, with addresses by 22 distinguished guest speakers. Attendance at these sessions will provide credit toward the hours required for AMA's Physician's Recognition Award, established for those beyond the stage of graduate training or education.

Headquartered in Birmingham, Ala., SMA is composed of more than 20,000 physician members in 16 southern states and the District of Columbia. The association's exclusive purpose is to develop and foster scientific medicine.



**Because you  
practice  
medicine in the  
Magnolia State...**

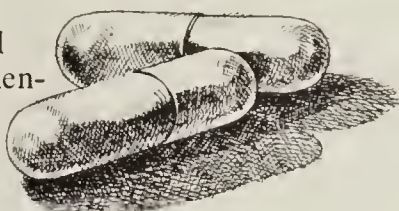




**You carry one of the heaviest patient loads in the country. Since this may include a number of patients with gastritis and duodenitis... you should know more about Librax®**

### **Helps reduce anxiety-related G.I. symptoms**

A patient may blame his attacks of gastritis or duodenitis on "something he ate" but contributing factors may be his job, marital problems, financial worries or some other unmentioned source of stress and excessive anxiety that exacerbated the condition. Whether it is "something he ate" or "something eating him," adjunctive Librax can help. Librax offers both the antianxiety action of Librium® (chlordiazepoxide HCl), that can help relieve excessive anxiety, and the dependable anticholinergic action of Quarzan® (clidinium Br), that can help reduce gastrointestinal hypermotility and hypersecretion.



### **Patient-oriented dosage — up to 8 capsules daily in divided doses**

For optimal response, dosage can be adjusted to suit patient needs—1 or 2 capsules, 3 or 4 times a day.

## **To help relieve anxiety-linked symptoms in gastritis and duodenitis adjunctive Librax®**



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions

in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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Nutley, New Jersey 07110

# Medical TV Network Schedules Drug Program

Antibiotic Misadventure: "The Case of Overkill," is the first of two related videotape programs slated for distribution this fall to more than 650 hospitals by The Network for Continuing Medical Education (NCME) as part of the nationwide Drug Spotlight Program, sponsored by the American Society for Clinical Pharmacology and Therapeutics.

The Drug Spotlight Program, initiated in April of this year, encourages pharmacy and therapeutic committees at local hospitals to review their therapeutic practices and, where necessary, improve drug therapy.

In this seven-minute television presentation, scheduled for showing Sept. 24 through Oct. 7, doctors are asked to test their prescribing ability by following day-to-day reports on a 70-year-old male patient admitted to the hospital with shaking chills, pleuritic pain, headache, fever and rapid respirations and pulse.

The program features Dr. Harold C. Neu, chief of infectious diseases at Columbia University College of Physicians and Surgeons, New York City.

Dr. Neu also is featured in the second program in this series, Antibiotic Misadventure: "The Case of Superinfection, Par Excellence," a 12-minute feature to be shown from Oct. 8 through Oct. 21.

This second program deals with a cachectic 71-year-old female patient who complains of extreme fatigue, nausea and fever. The case appears simple when it begins, but with continued antibiotic therapy one mistake follows another.

Viewers are asked to detect the mistakes before Dr. Neu points them out.

In the Drug Spotlight Program, a new group of drugs comes under study every three months. The October-through-December subject deals with the use of antibiotics.

"Anticoagulant Therapy" is the subject of future study, while "Antihypertensive Therapy" and "The Use of Hypnotics, Sedatives and Minor Tranquilizers" came under study in the first two segments of the Drug Spotlight Program.

The Network for Continuing Medical Education, located in New York City, produces 69 new medical television programs a year and distributes them on a bi-weekly basis to major hospitals, medical centers and medical schools in the United States and Canada. Roche Laboratories supports this independent medical education effort that reaches some 100,000 physicians across the country.

## SCHEDULE OF UPCOMING NCME PROGRAMS

Here are the playing dates and upcoming programs to be distributed by The Network for Continuing Medical Education (NCME):

Oct. 8-21 *How to Overdiagnose Pulmonary Embolism*, with Edward H. Morgan, M.D., Head, Respiratory Disease Section, The Mason Clinic, Seattle, Washington.

*What You and Your Patient Should Know About Coronary Arteriography*, with F. Mason Sones, Jr., M.D., Director of Cardiovascular Medicine and Cardiac Laboratory, and Donald B. Effler, M.D., Director, Department of Cardiovascular and Thoracic Surgery, both of The Cleveland Clinic.

*Antibiotic Misadventure: "The Case of Superinfection, Par Excellence,"* with Harold C. Neu, M.D., Chief of Infectious Diseases, Columbia University College of Physicians and Surgeons, New York City. (A Drug Spotlight Program feature.)

Oct. 22-  
Nov. 4 *Laparoscopic Sterilization*, with Thomas F. Dillon, M.D., Director of Obstetrics and Gynecology at Roosevelt Hospital, and Professor of Obstetrics and Gynecology, Columbia University College of Physicians and Surgeons, New York City.

*Transient Ischemic Attack—The History*, with Clark Millikan, M.D., Senior Consultant in Neurology, and Professor of Neurology, The Mayo Clinic, Rochester, Minnesota.

*Transient Ischemic Attack—The Physical*, with Clark Millikan, M.D., Senior Consultant in Neurology, and Professor of Neurology, The Mayo Clinic, Rochester, Minnesota.

For more information on MCME, write The Network for Continuing Medical Education, 15 Columbus Circle, New York, N. Y. 10023.



A grant from the Commonwealth Fund has made the Drug Spotlight Program possible.

Medical journals, bulletins and newsletters that are cooperating in the program by publishing related articles during the designated dates include American Family Physician; American Journal of Hospital Pharmacy; American Journal of Nursing; American Society of Hospital Pharmacists Newsletter; Annals of Internal Medicine; Association for Hospital Medical Education Journal; Bulletin of the American College of Surgeons; Hospitals (Journal of the American Hospital Association); Hospital Medical Staff (publication of AHA); Hospital Pharmacy; Journal of the American Medical Association; Journal of Medical Education; Patient Care; Perspectives on Accreditation; Postgraduate Medicine.

The NCME programs can be seen at the University Medical Center in Jackson on Tuesdays and Thursdays at 9 a.m. in the Research Conference Room. The Mississippi Regional Medical Program sponsors the program showings at Singing River Hospital, Pascagoula; Forrest General, Hattiesburg; Hinds General, Jackson; and Lafayette County, Oxford.

## UMC Calf Lives 24 Days With Artificial Heart

A 190 pound calf named Alice has earned herself a place in medical history.

She lived for 24 days, 13½ hours with a total artificial heart implanted by a team of University of Mississippi Medical Center researchers on Sept. 6, 1973.

It's a world's record for survival with a man-made heart. The previous record was just 18 days.

"We consider this a major breakthrough," said Dr. Tetsuzo Akutsu, the Mississippi professor of surgery who heads the research team. "The day when the artificial heart will be ready for man is getting closer."

Dr. Akutsu said when his team gets a month's survival consistently with at least 80 per cent of their implants, they'll be ready to put a mechanical heart in a patient waiting for a human heart transplant.

"Permanent implantation of a total artificial heart is a bit further away," the Mississippi researcher said. "We've got to have a nuclear power source that can be put in with the heart."

The Akutsu heart, made of silicone rubber, has the same operating principle as the natural heart's—alternate compression and relaxation of the blood-filled chambers. After the natural organ is removed, it is placed in the pericardium, the fibro-

serous sac that encloses the natural heart. The man-made device is tube-connected through the chest wall to an external power source. Air blown through the tubes starts the beat.

Dr. Akutsu attributed Alice's death to "blood clots which formed in the heart and then spread throughout the body."

Dr. Akutsu, who has designed more than 20 different types of total artificial hearts, has been on the Mississippi Medical Center faculty since 1966. He and Dr. Willem J. Kolff implanted the world's first man-made heart at the Cleveland (Ohio) Clinic in 1957. That animal lived for about an hour and a half.

## U. S. Navy Now Provides Speakers

As part of its new recruiting efforts, the U. S. Navy has assigned LCDR Gene F. Renfro, MSC, USN, to the staff of Navy Recruiting Area Three to develop an area program that will inform medical students and physicians about the Navy and its medical programs.

LCDR Renfro is now available for presentations or can provide movies, slides, or other information to interested groups.

For more information, call LCDR Renfro or Capt. C. C. Dudley toll free at 800-841-8000.

## Hair Symposium Set in Atlanta

The first Human Hair Symposium will be held in Atlanta Oct. 12-14, 1973, sponsored by the Hair Research Task Force, National Program for Dermatology, and the Division of Dermatology, Department of Medicine, Emory University School of Medicine.

Dr. Algie C. Brown, associate professor of medicine (dermatology) and director, Division of Dermatology, Department of Medicine, Emory, is chairman of the symposium.

The meeting will be held at Grady Memorial Hospital Auditorium and at Stouffer's Atlanta Inn.

More than 300 physicians, biomedical scientists, and others are expected to attend the three-day meeting. Forty scientific papers will be given on hair research in genetics, ultra-structure, chemistry, and forensic medicine.

Dr. Brown and his colleagues will discuss their work with the scanning electron microscope (SEM) in which they are studying hair as a technique for diagnosing many human diseases.

## Guyton Fund Board Meets

The Board of Trustees of the Billy S. Guyton, M.D., Memorial Medical Education Loan Fund met at the Medical Alumni House in Jackson on August 2.

Mr. C. W. Price, UMC Alumni Secretary, summarized the history of the Guyton fund and explained the program's purposes, governing by-laws and recent developments. He indicated that the Guyton fund is a working arrangement between the Medical Alumni Chapter, MSMA and the University Medical Center to perpetuate the ideals of Dr. Guyton and to provide financial assistance to students in the School of Medicine in such a way that the participants shall be assisting other generations of students through their very participation.

He further stated that during the 1972-73 academic year the fund's Board of Trustees had made an allocation to the School of Medicine of \$10,000 in the form of twenty \$500 loans for sophomore, junior and senior medical students who are native Mississippians and who exhibited financial need.

The board voted to approve the expenditure of twenty \$500 loans for the 1973-74 academic year also.

In discussion of fund raising efforts, those present suggested that the following three procedural methods be followed:

(1) Enlarge upon and increase the emphasis of Guyton Memorial by showing the results of the giving for this cause. "This is truly a Mississippi based loan fund for needy medical students."

(2) Encourage the MSMA Woman's Auxiliary to choose the Guyton fund as one of their important projects.

(3) Encourage medically related organizations or other institutions to participate in this effort to assist medical education in Mississippi.

## MHA Tri-State Scientific Session Planned

A postgraduate course entitled, "Controversies in Cardiology" will be held at the Broadwater Beach Hotel, Biloxi, May 16-17, 1974. Registra-

tion will be open Wednesday, May 15, from 4 to 6 p.m.

The course is sponsored by the Louisiana, Arkansas, and Mississippi heart associations and the American Heart Association Council on Clinical Cardiology. Course directors are: Dr. Albert Hyman, Louisiana Heart Association; Dr. Malcolm Pearce, Arkansas Heart Association; Dr. John Phillips, American Heart Association Council on Clinical Cardiology; and Dr. William H. Rosenblatt, Mississippi Heart Association.

The course will be concerned with management of arrhythmias, newer techniques in diagnosis, prosthetic valve surgery, exercise and diet in coronary heart disease.

Registration fee is \$75 for heart association members; fellows, associate fellows and members of American Heart Association Council on Clinical Cardiology; and \$100 for non-members. This includes social hour Wednesday evening; buffet luncheon Thursday and Friday; and coffee during breaks.

Application has been made to American Academy of Family Practice for 12 elective hours credit.

Further information may be obtained from Mrs. Pat H. Roundtree, Program Director, Mississippi Heart Association, 4830 East McWillie Circle, Jackson, Miss. 39206.

## EMCRO Holds ER Workshop



*The Experimental Medical Care Review Organization (EMCRO) recently held an Emergency Room Workshop for criteria development at the Coliseum Rainada Inn in Jackson. Emergency room physicians and EMCRO specialty panel physicians are shown participating in a full day of discussion and work sessions.*



## NHLI Seeks Grant Applications

The HEW's National Heart and Lung Institute is inviting young scientists and physicians nationwide to compete for grants to conduct pulmonary, or lung-related, research in projects of their own design and direction.

The new program—the "Young Investigator Pulmonary Research Grant"—is being launched this month by Dr. Claude J. M. Lenfant, director of the Institute's Division of Lung Diseases. Dr. Lenfant explains that, by providing them with modest independent support for projects of their own design, this program will help young scientists and physicians who are on the lower rungs of the professional ladder, while encouraging them toward pulmonary research, where new knowledge and diverse professional talents are greatly needed.

The division is inviting applications from young professionals across a broad, basic-clinical spectrum of fields, ranging from biochemistry and engineering to surgery and pediatrics. Each applicant must be under 35, with a doctorate in some relevant field.

Grant applications must be returned before Dec. 1, to be reviewed in time for next fiscal year's funds. Other information about this program may be obtained from: Jay Moskowitz, Ph.D., Acting Chief, Special Programs and Resources Branch, Division of Lung Diseases, National Heart and Lung Institute, Bethesda, Md. 20014.

## Dr. James Named UAB Medicine Chairman

Dr. Thomas N. James has been appointed chairman of the Department of Medicine at the School of Medicine, University of Alabama-Birmingham (UAB), according to Dr. James A. Pittman, dean of the school.

Dr. James is also director of the Cardiovascular Research and Training Center, as well as professor of medicine and professor of pathology. In his positions with the UAB, Dr. James has held a leadership role in developing programs dealing with research, teaching and treatment of heart disease.

A frequent consultant to the National Heart and Lung Institute and officer of many national organizations in his specialty, Dr. James is best known for his work on the coronary arteries and

the processes dealing with the normal and abnormal electrical activity of the heart (its rhythm).

"As director of CRTC, Dr. James has shown himself to be an able administrator," said Dr. Pittman. "UAB also extends its appreciation to Dr. T. W. Sheehy who served with distinction as chairman of the department in the interim following the resignation of Dr. T. Joseph Reeves."

Dr. Reeves, who resigned from the position in April, 1973, retains his appointment as professor of medicine in the department.

## CHAMPUS Coverage Relates to Medicare

Under the Social Security Act of 1972, people under 65 years old who receive Social Security benefits for the disabled are now eligible for hospital benefits under Part A of Medicare. Public Law 89-614, under which CHAMPUS was enacted, states that retired members and their dependents and the dependents of deceased personnel are not entitled to benefits under CHAMPUS if they are eligible for hospital insurance benefits under Medicare.

The assistant Secretary of Defense for Health and Environment has not been able to complete the coordination with the Social Security Administration which he feels is necessary to establish a final CHAMPUS implementation of these new Medicare eligibility provisions of the act.

Pending completion of the necessary coordination of the CHAMPUS and Medicare claim procedures, the following procedures will be followed in the adjudication of CHAMPUS claims:

(1) Claims from dependents of active duty members will be processed without regard to any possible Medicare eligibility.

(2) Claims from retired members and dependents and survivors of deceased active duty and deceased retired members, will be processed in accordance with procedures now in effect with respect to persons age 65 and over who do not have Part A coverage under Medicare or who have Part B only. With respect to the Medicare 1972 Amendment coverage, the CHAMPUS cost-sharing shall be determined without regard to any new Medicare coverage unless the claim itself states the amount of the Medicare payment. In this case, the amount paid by Medicare shall be considered in determining CHAMPUS cost-sharing under the procedure now in effect with respect to other health plans, as outlined in OCHAMPUS Fact Sheet 21-1, dealing with CHAMPUS and "other health insurance."

## Texas Plans Satellite Health Education

A "space university" of health education, with televised programs originating in San Antonio, relayed from Austin to a satellite, and then beamed to hundreds of hospitals in mid-United States, will get under way in early 1976.

The project will be conducted by The University of Texas Health Science Center and School of Nursing at San Antonio. It will use the extensive technical resources of the Communication Center of The University of Texas at Austin with the cooperation and support of all the other UT components.

The vast new venture is called APACHE (Astral Program for the Advancement of Continuing Health Education). Now in the planning stages, it will begin telecasting about January, 1976.

APACHE will be a part of an educational communication experiments package to be made available by the National Aeronautics and Space Administration (NASA) through its planned Communications Technology Satellite (CTS) which will be produced by the San Antonio health science center with aid from the other UT units for four health professional groups: physicians, dentists, nurses and paraprofessionals such as pharmacists, dietitians, social workers and various types of technicians.

The project will make continuing health education available to thousands of professionals, many of whom live and work in areas remote from educational centers.

The San Antonio health science center, aided by communications support at UT-Austin, is the only institution awarded time on the satellite for programming in all forms of health education.

Said President Frank Harrison, "The APACHE Project will be the only one of its kind anywhere. This exciting venture puts health education into the space age and is a major step toward reaching people in otherwise inaccessible areas."

"The project," he continued, "will direct further national and even international attention to the health science center which has rapidly acquired a reputation for leadership and expertise in continuing health education."

APACHE was conceived and will be implemented by Dr. Paul Cutler, professor of medicine and associate dean for clinical affairs at The University of Texas Medical School at San Antonio (a component of the health science center)

and by Dr. John Fryman, coordinator of closed-circuit television under the School of Communication at The University of Texas at Austin. Dr. Cutler will be responsible for programming content while Dr. Fryman will coordinate the technical equipment and signal transmission sector.

Dr. Fryman explained that the videotaped and live programs will be transmitted via microwave from San Antonio to Austin. Using electronic equipment at the expansive new Communication Center on the Austin campus, programs will then be beamed to the satellite which will be positioned over the Galapagos Islands in the South Pacific.

The satellite will transmit the programs in sound and color to special closed-circuit receivers in a 1.5 million square mile area roughly encompassing the distance from east of the Mississippi River into the Rocky Mountains, and from Canada to the Gulf of Mexico. Twenty-two states will be included. "An important implication of this project is that local sites will be receiving signals directly from space," Dr. Fryman said, "and not through an intermediate distribution system such as community cable TV."

It is foreseen that hundreds of hospitals, clinics and community agencies in the area will become receiving centers where groups of professionals will gather to view the programs. Local taping for delayed playback will be possible.

## Physician Astronaut Keynotes AAP Meeting

Dr. Joseph L. Kerwin, the first physician in space, will present the keynote address during the 42nd annual meeting of the American Academy of Pediatrics, Oct. 20-24 in Chicago.

The meeting, to be held in the Palmer House Hotel, is expected to attract more than 4,500 persons including pediatric specialists from throughout the western hemisphere.

Dr. Kerwin was part of the three-man crew of Skylab 2, the first manned Skylab mission. He and his fellow astronauts spent a record-breaking 28 days in space during May and June of this year.

Dr. Kerwin's work with the National Aeronautics and Space Administration dates back to 1965 when he was selected as a scientist-astronaut.

A native of Oak Park, Ill., Dr. Kerwin received his M.D. degree from Northwestern University Medical School in 1957. He completed his internship at D. C. General Hospital in Washington, D. C., and subsequently attended the U. S. Navy



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Volume XIV

Number 11

November 1973



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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$7.50 per annum; \$1 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri.

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# Pinworm therapy is often a family affair



**Contraindications:** History of hypersensitivity to thiabendazole.

**Warnings:** If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.

**Precautions:** Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction,

patients should be carefully monitored.

**Adverse Reactions:** Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopenia; malodor of the urine, crystalluria, hematuria; appearance of live *Ascaris* in the mouth and nose. Hypersensitivity reactions





ORIGINAL PAPERS

# Management of Acute Dissecting Hematoma of Aorta

ERNESTO CHING, M.D., JAMES D. HARDY, M.D., and  
AKIO SUZUKI, M.D.  
Jackson, Mississippi

ACUTE DISSECTING hematoma of the aorta is due to degenerative disease of the tunica media of the aorta, e.g.: cystic medionecrosis, Marfan's syndrome, etc.; but occasionally may be atherosclerotic. Depending on the anatomic extent of dissection, three types of dissecting hematoma are described:

Type I—Cases where dissection extends from ascending aorta into the arch and beyond, 60-70 per cent of all cases.

Type II—Cases where the lesion is limited to ascending aorta. This small group typically has Marfan's syndrome.

Type III—Cases where dissection begins distal to the arch vessels and in which an intimal tear is found in the proximal descending aorta, 20-30 per cent of all cases.

The sudden onset of excruciating chest pain that radiates to the back and reaches its peak intensity is a classical symptom of dissecting hematoma of the thoracic aorta. Another 20-40 per cent of patients may present with neurologic symptoms and signs; others where pain is completely absent (less than 10 per cent of cases) are most commonly associated with Marfan's syndrome and ascending aortic dissection, Type II. Hypertension occurs in 80 per cent of patients when first seen in the Emergency Room and should alert one to suspect the presence of such a malady. Between 20-30 per cent of these pa-

tients may present with aortic regurgitation murmur resulting from detachment of aortic valve cusp and infrequently one encounters a friction rub of pericarditis type secondary to blood leaking

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*Acute dissecting hematoma of the aorta is due to degenerative disease of the tunica media of the aorta, e.g.: cystic medionecrosis, Marfan's syndrome or atherosclerosis. The authors describe three types of dissecting hematoma and emphasize the importance of suspecting the lesion, instituting appropriate supportive measures and transferring the patient safely to a medical center where surgical correction could be carried out.*

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into the pericardial sac. A widened mediastinum on plain chest x-ray or left pleural effusion is frequently seen on initial examination. Nevertheless, a normal chest x-ray with normal EKG is not frequently seen, but this does not rule out dissecting hematoma. When a dissecting hematoma is suspected by the attending physician of a community hospital who does not have the facilities to handle this condition, he should immediately contact a medical center and arrange for transfer of such patient, either by ambulance or helicopter or other means which serve the patient best. The natural history of dissecting hematoma is such that the mortality of those who are untreated is:

---

From the Department of Surgery, University of Mississippi School of Medicine, Jackson, Miss.

20 per cent will die in 24 hours, 60 per cent in two weeks, and 90 per cent in three months time.

The aim of the community hospital attending physician is to stabilize the patient's condition and transfer him to centers where help and definitive treatment could be carried out. The following are steps to be taken:

1. Shock—If evidence of bleeding with hypovolemic shock is present, compatible blood and/or plasma should be given. This encompasses all the features of how to treat hypovolemic shock and will not be expanded here. Needless to say, a couple of large bore plastic catheters should be inserted in peripheral veins, ideally with central venous pressure monitoring.

2. Heart failure—Rapid digitalization is indicated if this feature is present, preferably with intravenous Digoxin.

3. Relief of pain and anxiety—Use of morphine sulfate in small doses, 2-4 mg, intravenous, frequently alternating with a tranquilizer such as valium is most appropriate.

4. Therapy of hypertension—As stated earlier, hypertension occurs in 80 per cent of all patients presenting with dissecting hematoma. Wheat's program of hypotension therapy should be instituted if significant hypertension is present. This medical program is aimed at producing a negative inotropic effect via the use of a combination of drugs, namely, reserpine, propranolol, trimethaphane and guanethidine. A flatter pulse wave (lower Dp/Dt) may be accomplished with the above mentioned therapy and thus discourage further dissection. To obtain the above desired effect, an indwelling arterial line for continuous arterial blood pressure monitoring is mandatory. The systolic blood pressure is kept between 100-120 mm mercury and a continuous urine volume of

more than 30 cc per hour should be obtained. Once the patient is stabilized, he may be transferred to a medical center where diagnostic work-up, including aortography, is performed.

Acute dissecting hematoma is a surgical emergency; vigorous medical supporting therapy is a temporary measure to buy time until definite surgical therapy could be carried out safely in six to eight weeks under optimal conditions. Our present indications for immediate surgical correction of aorta dissecting hematoma are:

1. Involvement of major aortic branch
2. Pressure of saccular component to the aneurysm
3. Massive aortic regurgitation
4. Blood in pleural spaces
5. Uncontrolled shock and hypotension
6. Progressive dissection despite hypotension therapy

In conclusion, the most important message to remember in dissecting hematoma is suspicion of its presence and once suspected, appropriate supportive measures instituted and transfer of patient safely to a medical center where surgical correction could be carried out effectively. ★★★

2500 North State Street (39216)

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## DEPARTMENT OF PSYCHIATRY

Is insanity hereditary?

Yes, your children can drive you crazy.

—Nebraska Medical Journal



# Fluoridation: Scientific, Economic, and Medicolegal Aspects

J. DANIEL MITCHELL, M.D.

Jackson, Mississippi

IT HAS BEEN SCIENTIFICALLY established that fluoridation of public water supplies is highly beneficial in preventing dental caries, particularly in children among whom such prevention is vitally needed. Fluoridation also benefits adults, but more importantly, as children who have had the benefits of fluoridated water become adults, they retain the benefits. Thus, there is the ideal potential that the entire population can be protected for life.

Dozens of valid and accepted studies demonstrate that fluoridated water reduces the DMF (decayed, missing, and filled teeth) by a rate of 60 per cent. This is the experience in Mississippi.

Fluoride is fluorine and another element in a binary compound. It occurs naturally in upper geologic mineral layers of the earth, frequently providing a natural source of fluoridated water. It is extracted commercially for processing and use, largely for health purposes.

So fluoridation of water supplies is nothing new. Hundreds of millions have drunk such water for hundreds of years, and addition of fluorides has been an established health practice for over 30 years. The adjustment necessary to benefit in dental health is to achieve one part of fluoride to one million parts of water (1:1,000,000). This is about one drop for 13 gallons.

Before considering the health benefits, it is appropriate to say what fluoridation is not as well as what it is:

—It has absolutely no effect, adverse or otherwise, on industrial processes.

—It is in no way, absolutely no way, harmful to home and industrial plumbing systems or to city water plants and distribution systems. Dozens of engineering studies and surveys and inspections prove this.

—It does not in any way affect the taste, color, or odor of water.

On a cost-benefit basis, fluoridation is one of the few real bargains left. In Mississippi, a municipality can maintain a complete fluoridation program for a dime a citizen a year or less. Considering a 60 per cent reduction in decayed, missing, or filled teeth in return for such an inconsequential expenditure, cost cannot rationally be a factor in any discussion of fluoridation.

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*Fluoridation of public water supplies, long supported by the responsible scientific community, is beneficial, economical, and legal. The two-decade old program in Mississippi has demonstrated major benefit in prevention to a substantial extent of the most prevalent disease of childhood, carious teeth.*

*For the first time in the literature, the author, who presided over a major study of fluoridation commissioned by the City Council of Jackson, Mississippi, simultaneously examines the scientific, economic, and medicolegal aspects of this formerly controversial but now accepted preventive practice.*

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These studies included examination of data researched on 242 Mississippi communities among which fluorides occur naturally in 157, a natural occurrence of 64.88 per cent. It is true that the amount of fluorides occurring naturally usually does not measure up to the recommended level of 1 ppm, they are nonetheless beneficial. The ppm range held beneficial by the dental profession, and concurred in by the medical profession, is from 0.8 ppm to 1.2 ppm.

Forty municipalities in Mississippi have instituted water fluoridation programs, including Jackson. Each is benefitting substantially from these programs in improved dental health.

Columbus was a pioneer in initiating a water fluoridation program, beginning in August 1951. In 1965, dental scientists made studies of the Columbus experience and made comparisons

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Chairman, Central Mississippi Health Planning Council.  
Adapted from a study commissioned by the City of Jackson.

## FLUORIDATION / Mitchell

against then-unfluoridated cities which were Greenwood, Hattiesburg, Jackson, Natchez, and Vicksburg. These studies have been published by Aaron Trubman, D.D.S., M.P.H., director of the Division of Public Health Dentistry, State Board of Health. Dr. Trubman's research has been confirmed and widely concurred in by the scientific community. The beneficial results were determined by actual examination of 8,069 children in the six cities by dentists and dental hygienists using mouth mirrors and sharp explorers. All teeth in every child were examined, and results were individually recorded for subsequent tabulation.

To assure validity beyond question, the examining professionals counted as caries only obvious carious lesions. In less scientific terms, these are cavities needing to be drilled and filled or, in some instances, causing the loss of the tooth.

This extensive, diligent individual professional examination assured validity, because it is sufficiently large to rule out chance of distortion of the true effect of fluoridation and nonfluoridation. The data are presented in Table I.

TABLE I  
EXAMINATIONS FOR CARIES

Age	5 Nonfluoride Cities	Columbus
6	1,287	108
7	1,311	133
8	1,259	119
9	1,297	91
10	1,182	100
11	1,130	52
Total all ages	7,466	603

The researchers and investigators expressed their findings in DMF rates, and it should be remembered that nothing can help a missing tooth and that a filled tooth derives less benefit from fluoride than a healthy, unfilled tooth. The Columbus children, on an age-to-age comparison, had DMF rates 46.5 to 60.4 per cent *lower* than the children in the then five non-fluoridated cities.

In addition to the significantly lower prevalence of dental caries in permanent teeth of the Columbus children, the percentage of them affected by the disease of carious teeth also ranged *lower* by 26.2 to 50.8 per cent than the children in the then five nonfluoridated cities.

The DMF rates expressed in Table II are the number of DMF teeth per child actually found at examination.

TABLE II  
DMF RATES

Age	DMF Rate in Nonfluoride Five Cities	Columbus	
		DMF RATE	PER CENT LOWER
6	0.53	0.21	60.4
7	1.27	0.53	58.3
8	2.11	1.01	52.1
9	2.53	1.27	49.8
10	3.25	1.74	46.5
11	3.91	1.85	52.7

The comparison of experience after 11 years in Columbus with children of the same age groups in five then-nonfluoridated cities confirms the benefits of the program. Further, research reports published nationally tend to confirm that where children have the benefit of fluoridated water from very early childhood, the incidence of malocclusion is greatly reduced in comparison to nonfluoridated areas. It is believed that this further dental health benefit results from prolongation of the life of deciduous teeth and the first permanent molars.

Other benefits of fluoridation are obvious:

- A great reduction in loss of teeth.
- A great reduction of pain and the pain of treatment.
- A great reduction in the cost of dental care.
- A greater awareness by the public that prevention is a major facet of dental science strongly supported by medical science.

Tooth decay is the most prevalent disease of childhood, and previous investigations demonstrate that by or before reaching the teen years, 90 per cent of our children have been affected by carious teeth. The ravages of the disease are not to be dismissed lightly, because it frequently becomes the underlying and proximal factor to serious dental disease in adulthood and not altogether infrequently, in other, nondental disease.

It is apparent that fluoridation of public water supplies does not and cannot eliminate dental caries, but the benefits of fluoridation can reduce it by half. It does not and cannot replace conscientious application of personal dental hygiene: We must use brushing and a safe, suitable dentifrice, preferably after each meal or eating. It does not, cannot, and must not be conceived as diminishing the need for regular professional dental care.



A few vociferous individuals oppose fluoridation of water supplies with a fervor difficult to describe. Some are no doubt sincere, some proceed on ideological bases substantially differing from those of a vast majority of their fellow men, and most are patently misinformed. None can make a case against fluoridation on a scientific basis.

A few argue that fluoridation adversely affects bones in the human body. All bones contain fluorides, and the body provides physiologic mechanisms for keeping systemic fluorides in balance. Of course, toxic amounts ingested can be harmful, something which is true of virtually any element or substance. For example, it is necessary to drink 120 quarts of fluoridated water at one sitting to produce nausea, a temporary discomfort which we will not likely be called to treat. Modern water plant equipment makes accidental or even intentional overdosing of our supplies with fluorides impossible.

Reporting in *Pediatrics*, Schlesinger said that "There have been no well-documented reports on nondental effects from water containing even several times the concentration of fluoride recommended for prevention of dental caries. The 10-year study of comparable children in Newburgh and Kingston, N. Y., failed to show any nondental differences that could be ascribed even remotely to the ingestion of fluoridated water."

He also reported that "no roentgenographic changes have been found in the bones of adults up to 78 years of age who have been using water containing between 1.2 and 3.0 ppm of fluoride over extended periods of time."

In Bartlett, Texas, where naturally occurring fluorides are an astonishing 8.0 ppm in the water, a comparison of 37 years of experience against adults drinking natural fluorides in nearby Cameron with 0.4 ppm showed no significant differences in diseases or rates of diseases between the two adult groups in nearly four decades. Overall in documented mortality, careful comparison, even on age-adjusted bases, shows no differences in death rates from heart disease, cancer, nephritis, diabetes, and cirrhosis among cities having widely varying levels of fluorides—or no fluorides—in water.

So it is known, documented, and scientifically accepted that in dozens of communities involving millions of individuals compared with fluoridated and nonfluoridated water supplies:

—There is no difference in death rates among older individuals.

—The incidence of various illnesses is unaffected.

—And the only difference is a significant reduction in dental decay where fluorides are used.

A very few militant individuals contend that fluoridation is "mass involuntary medication, invasion of privacy, denial of liberties, and even a violation of the Constitution of the United States," although none apparent in this research and that reviewed could be considered Constitutional authorities.

In the first place, fluorides are not medication, for the simple reason that fluorides are not being used to treat diseased teeth. Fluorides are necessary dental nutrients which render teeth more resistant to decay. The same militants are silent on other chemicals used to make our public water supplies safe for ingestion, and few limit their diets to organic purity, for our foods contain a wide variety of additives, carefully controlled under federal statute and FDA inspection and regulation.

Historically, society has reserved the right, through the orderly process of law, to protect itself from dangers to life and health. Immunization against disease, isolation of certain diseases, minimum health and sanitation requirements, and an endless array of such measures date back to the birth of the Republic.

In *Jacobson v. Massachusetts*, the United States Supreme Court held that "the liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. . . ." This was held in a case claiming that a compulsory vaccination statute was unreasonable, and the statute was upheld.

Recognition of community health as a proper subject for the exercise of the police power was upheld by the Louisiana State Supreme Court in *Chapman v. City of Shreveport*, stating that the "health of the children of a community is of vital interest and of great importance to all of the inhabitants of the community. Their health and physical well-being is of great concern to all of the people, and any legislation with regard to retard or reduce disease in their midst cannot and should not be opposed on the ground that it has no reasonable relation to the general health and welfare."

The plaintiffs, bringing the suit against a compulsory health law, had their appeal dismissed by the Supreme Court of the United States, case same styled.

In *Dowell v. City of Tulsa*, the court took judicial notice of the fact that the health of teeth bears a direct relationship to general physical health.

In a suit against fluoridation, *Kraus v. City of Cleveland*, the court held that whether a par-

ticular disease presents a problem of public or private health does not turn on whether it affects a few or many or whether it is contagious, but rather on the ability of the public authority to effectively cope with it. The city and the fluoridation program were upheld, and the plaintiffs were denied appeal by the Supreme Court of the United States, case same styled. The appellate court, in upholding fluoridation, said:

Under our modern existence, the law must change and expand with mechanical and scientific progress. What did not concern public health yesterday, because of an inability of science to cope with the problem at hand, may very well become a matter of public health due to scientific achievement and progress. The use of fluoridation to prevent dental caries is an excellent example of this proposition. Science has discovered a method whereby dental caries may be diminished. The prevalence and danger of such caries are well known and the only practicable application of such scientific knowledge is by treating drinking water with fluoride. Thus the problem of dental caries has of necessity become one of public health.

From the legal viewpoint, it is sufficient to state that legal precedent is ample, consistent, and widely applied. The Supreme Court of the United States has neither addressed itself to fluoridation nor has it granted review to suits in opposition to it.

In addition to the U. S. Supreme Court refusing review of fluoridation cases on four occasions, state supreme courts in seven jurisdictions have upheld it. Appellate decisions are too numerous to list in support of this preventive measure, and the legal literature is replete with such precedents.

As recently as the 1950's, conservative scientists of high competence and repute reserved judgment on the benefits of fluoridation. Such reservations have evaporated in the face of scientific validation. About the only opposition remaining appears to repose on tenuous ideological and emotional grounds, and such opponents almost invariably generate more heat than light in their militancy.

One such argument is that fluorides mottle teeth, producing an undesirable cosmetic effect. It has been demonstrated that even mild mottling may not be conclusively imputed to use of fluoridated water with the recommended content range of 0.8 to 1.2 ppm.

In their joint study of the effect of fluoridated

water for 10 years in Grand Rapids-Muskegon, Michigan, published in Public Health Reports, Arnold (director of the National Institute of Dental Research), Dean (secretary of the Council on Dental Research, American Dental Association), Jay (professor of dentistry, University of Michigan School of Dentistry), and Knutson (Chief Dental Officer of the U. S. Public Health Service) clearly and candidly stated that there is "no undesirable cosmetic effect from dental fluorosis from use of fluoridated water."

Even after 10 years of use in the Grand Rapids-Muskegon area, the statistically insignificant and mild fluorosis found to occur did not affect the anterior teeth and produced no undesirable cosmetic result of any significance in the posterior teeth.

Schlesinger states that "no disfiguring mottled enamel has been found in any children in the long-term studies, and the groups examined undoubtedly included children with extremes in water intake."

He continues, demonstrating the validity of the finding even further, stating that "the allegation that discoloration of teeth of children drinking fluoridated water appears with advancing age is also without foundation. In moderate and severe dental fluorosis, there are breaks in the continuity of the enamel and it is in these breaks that disfiguring stains develop. Such breaks are not found in the questionable to mild stages in dental fluorosis present in a small proportion of children receiving fluoridated water. No disfiguring fluorosis was found among these children, nor is there any likelihood of discoloration developing later in life in the presence of unbroken surfaces of enamel."

Frequently, a majority of the handful of opposition militants to fluoridation argue that alternate methods of securing its benefits are available without "infringement upon personal liberties," despite the U. S. Supreme Court having laid this flimsy premise to rest seven decades ago. Among these are:

—Why not fluoridate home water systems on a voluntary basis?

Great, but we might just as well build our own residential, private hospitals as far as the economics go. Nor would such be a safe procedure, either, for modern water plants, engineering techniques, careful controls conducted by public health authorities would be missing. It is neither practical nor economical.

—Why not take fluoride tablets?

The first reason is a good one: It would cost about \$3 per family member per month. Of equal importance, the dosage would have to be



custom tailored to the individual to attain adjustment to the fluoride content naturally occurring in local water supplies. Low income, disadvantaged families, greatly in need of these benefits, would be denied them. And getting people to take long-term dosage forms, even medicines, is notably unsuccessful. Maintenance of penicillin prophylaxis in children with rheumatic heart fever over a long period is difficult with devoted parents sometimes failing this task.

—Why not add fluorides to milk?

Two of the best reasons in the world: Dairies could not possibly add the correct amounts for proper adjustment of fluoride content to complement local water supplies and market and distribute such milk economically. The cost would be astronomical, and relatively few children could have such benefit. Second, many children drink little or no milk. On the other hand, consumption of water is fairly uniform, and it is available to all in the community.

—What about fluoridated toothpaste?

Hey, daddy, no cavities! It looks good on television, but the cold scientific facts are that fluoridated dentifrice is little more than a topical application, and topical methods, as recognized by cognizant dental authorities, are far less effective in prevention of caries than protection in water supplies which are literally built in for life.

Support of fluoridation of water supplies by the scientific, civic, and governmental communities is virtually universal. A partial listing of endorsing agencies, entities, and organizations include:

American Academy of Pediatrics  
American Association for the Advancement  
of Science  
American Association of Public Health  
Dentists  
American Cancer Society  
American Dental Association  
American Hospital Association  
American Legion  
American Medical Association

American Nurses Association  
American Pharmaceutical Association  
American Public Health Association  
American Society of Dentistry for Children  
American Waterworks Association  
Association of State and Territorial Dental  
Directors  
Association of State and Territorial Health  
Officers  
College of American Pathologists  
Commission on Chronic Illness  
Mississippi Dental Association  
Mississippi State Board of Health  
Mississippi State Medical Association  
Mississippi Public Health Association  
National Congress of Parents and Teachers  
National Junior Chamber of Commerce  
National Research Council  
United States Air Force  
United States Army  
United States Navy  
United States Public Health Service

Research and preparation of this study speaks for the position of the Central Mississippi Health Planning Council. In all cases, the Mississippi affiliates, chapters, and constituents of the national agencies and organizations listed have also endorsed fluoridation of water supplies. ★★★

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Political speaker: There are 100 jails in this state and I'm proud to say that no member of my family has ever been in one of them.

Voice from the rear: Which one is that?

# The Traditional Oriental Medicine and Acupuncture Therapy

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ACUPUNCTURE is a traditional therapy used in the Orient to treat disorders of internal viscera through stimulation of the body surfaces by needles. It is described in the *Yellow Emperor's Classic of Internal Medicine* written in China about 500 B.C.<sup>6</sup>

It was known to the Chinese physicians of that era that patients with disorders of internal viscera complained of pain not only over or in the vicinity of the diseased viscera but also at some distant areas of the body or extremities. When these areas were gently massaged, the pain in the diseased viscera was said to have been alleviated or disappeared completely. Based on these observations, they mapped out points of dermal projection of internal viscera on the surfaces of the body and extremities. These points were utilized first in massage long before the development of acupuncture therapy.<sup>7, 9</sup>

The special form of ancient Chinese massage, the utilization of points of dermal projection of internal viscera, was later greatly refined when needles were introduced as a source of specific stimuli. When varying amounts of needle stimulation were applied to the points of dermal projection of internal viscera on the body or extremities, varieties of therapeutic effects were observed depending upon the intensity and location of the stimuli. These observations were documented and organized in order to establish the therapeutic basis of acupuncture. Angiology and osteology were simultaneously cultivated as a topographical aid for the localization of acupuncture points.<sup>8</sup>

The therapeutic value of acupuncture has been recognized beyond question in the Orient for more than 3,000 years, but has not been well known in the Western hemisphere until recently. During the past 30 years, a number of textbooks on acupuncture have been translated into major European languages.<sup>11-17</sup> The results of clinical trials have been documented, and further research is in progress in many hospitals and medical centers in France, Germany, Great Britain, Italy, Switzerland, Poland, Czechoslovakia, and the U.S.S.R.<sup>18-25</sup> In France, acupuncture is now being taught within the curriculum of the teaching hospitals.<sup>20</sup> In Russia, after the completion of basic research, acupuncture is going to be a part of medical practice.<sup>21</sup> In America, recent reports by Veith<sup>11</sup> and Dimond<sup>101</sup> have generated widespread interest among physicians.

During the past 3,000 years, countless cases of various diseases have been treated by acupuncture in China, Japan, Korea, and many other countries in Asia. Some of these cases are on record and available for review. More recently documented cases and data from laboratory investigation have also been published in many medical journals in Europe.

In summary, various medical diseases, often considered to be diseases of neuro-vegetative and endocrine disorders, such as essential hypertension, Cushing's Syndrome (bilateral adrenal hyperplasia), dysfunctional uterine bleeding, diabetes mellitus, rheumatism, idiopathic neuralgia (trigeminal neuralgia, intercostal neuralgia, lumbosacral root syndrome), vasomotor rhinitis, glaucoma, peptic ulcer, spastic colon, asthma, and various dermatoses are treated with good to excellent results.<sup>9, 26-43</sup> Acupuncture for anesthesia and treatment of psychoneurosis and enuresis is also reported with favorable results.<sup>44-54, 101</sup>

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Acute infectious diseases, such as tonsillitis, otitis media, malaria, upper respiratory infection, gastro-enteritis, appendicitis, food poisoning, peritonitis, nephritis, and hepatitis are also treated with good results.<sup>9, 33, 34, 53-64</sup> Chronic organic diseases are more resistant to treatment, usually requiring longer periods of time ranging from several months to several years, depending upon the degree of chronicity and preexisting structural damage, and often the cure is incomplete.<sup>10, 41, 56, 65</sup> Malignant neoplasms are resistant to acupuncture therapy, although relief of pain or enhancement of general well-being is often obtainable. Acute surgical diseases, such as perforated viscus, are, needless to say, contraindications to the acupuncture therapy.

In the traditional Oriental medicine, the skin and internal organs are considered to be very closely interrelated. Clinicians have long realized that the surface of the body exhibits numerous rather well defined reflex zones to which the viscera refer their expression of dysfunction or pathology and from which visceral malfunction may be realized. It is important to indicate that the acupuncture points correspond very well with Head's areas of referred pains. According to Head's postulate, the cutaneous pain felt in visceral disease is located in the areas where sensory nerves enter the spinal cord at the same segments which supply nerves to the viscera concerned. Therefore, it is not unreasonable to postulate that the cutaneous stimulation by needles is also transmitted to the internal viscera through similar pathways. Evidence to support this postulate is submitted by Kuo and his associates in their studies of the bladder function in response to acupuncture.<sup>66</sup> Using a manometric apparatus, they have shown changes in the intravesical pressure of the urinary bladder after acupuncture. Similar observation is also reported by Tang in his study of the effect of acupuncture on the motility of the stomach.<sup>67</sup> It appears that various cutaneous stimulations by needles are, in part, transmitted to the internal viscera through the somato-visceral neuronal synapses in the spinal cord. And, during the process of such synapses, one of the components of the visceral nerves—either the sympathetic or the parasympathetic—seems to be selectively stimulated, thus normalizing the function of the autonomic nervous system. Evidence to support this view is submitted by Grashchenkov and his associates. They have demonstrated changes for normalization in the blood content of sympathetin, adrenalin, diamine oxidase, acetylcholine, acetylcholine esterase, and histamine in their patients with asthma and peptic ulcer after acupuncture.<sup>68</sup> It is, however, quite possible that such a normalizing effect of acupuncture

on the function of the autonomic nervous system may be mediated at the level of the thalamus rather than in the spinal cord. In any event, it is clear from the Grashchenkov's data that acupuncture does exert its action on the autonomic nervous system for the normalization of its function.

In the traditional Oriental medicine, the skin and nervous system are also considered to be very closely interrelated. This is understandable in view of the fact that the skin and nervous system are derived from the same embryological tissue. Through the studies of neurodermatitis and other chronic dermatoses, ancient Chinese physicians were aware of the close relationship between the two. Evidence to support this view is presented by Rasmussen and Penfield.<sup>69</sup> According to their investigation of the cerebral cortex of man, each area of the skin surface of the body and extremities has a representative area in the cerebral cortex. Therefore, dermal stimulation of various kinds on the body and the extremities is transmitted into the specific areas of the cerebral cortex in some specific manner and influences its function. This observation has been further corroborated by Kassil and associates at the Reflex Therapy Laboratory of Moscow. They noted specific changes in the patterns of electroencephalograms and electromyograms after acupuncture.<sup>70, 71</sup>

We now know that the cerebral cortex can exert influences on ACTH production through the reticular activating system.<sup>86, 87, 90</sup> We also know that the anterior pituitary stimulating action of the hypothalamus can further be influenced by impulses generated in the limbic system.<sup>88-90</sup> Specific stimulation of the skin by acupuncture seems to influence functions of the brain and subsequently the hypothalamus and its subordinated endocrine glands in some specific manner. It is demonstrated by Boeva and his associates that stimulation acupuncture produces an increase in endogenous production of ACTH, and subsequently an increase in adrenocortical hormones.<sup>54</sup> Their investigation revealed that stimulation acupuncture produces an effect similar to that seen following the injection of 25 international units of ACTH.<sup>54</sup> These findings are of extreme interest when reviewed in conjunction with the reports by Mandell and others who demonstrated that stimulation of one of the limbic structures, the amygdala, produces 17-hydroxycorticoid release, while stimulation of another limbic structure, the hippocampus, reversed the effects of previous amygdala stimulation.<sup>88, 90</sup>

In the traditional Oriental medicine, the primary cause of functional disturbances of internal organs is considered to be excessive mental stimu-

lation; that is, the seven emotions of anger, joy, worry, threat, sadness, fear, and surprise. For example, in the traditional Oriental medicine, a symptom complex that is known in the Western medicine as an essential hypertension is considered to be caused, at least in part, by some functional disturbances of internal organs due to excessive emotional stress. Evidence to support this view is also submitted by many Western investigators. In 1964, Barajas, using the electron microscope, demonstrated nerve endings, which appear to be sympathetic, in association with juxtaglomerular cells as well as arteriolar smooth muscle cells of the kidney.<sup>72</sup> Tobian and his associates, in the same year, demonstrated a marked increase of renin in the renal veins if epinephrine and norepinephrine are infused into the renal arteries of dogs.<sup>73</sup> Rapid degranulation of juxtaglomerular cells was also demonstrated under similar conditions of epinephrine infusion in rats by Kamura and Niwa in 1965.<sup>74</sup> These findings support the view that the production of renin, and subsequently angiotensin, is at least in part under nervous control. As demonstrated by Kassil and his associates, reduction acupuncture can lower the blood pressure by reducing the blood content of adrenalin and adrenalin-like substances.<sup>70, 71</sup>

On the other hand, stimulation acupuncture can elevate the blood content of adrenalin and adrenalin-like substances as demonstrated by Boeva and his associates.<sup>54</sup> The results of the aforementioned laboratory investigation are in agreement with the author's clinical experience.

Chronic pyelonephritis, often present in patients with hypertension, is worth comment. In Oriental medicine, chronic pyelonephritis is considered to be the manifestation of imbalanced physiological homeostasis in the kidney, with a view that a bacterial infection is only secondary. The current concepts of chronic pyelonephritis in Western medicine also support this view. Recently, evidence has been offered that a high local concentration of ammonia, as may be present when the body is dealing with an excessive acid load in cases of various metabolic acidoses, is sufficient to inactivate complement, thus rendering ineffective a major defense mechanism against bacterial infection.<sup>75</sup> It should be noted here that the dietary therapy in Oriental medicine for the treatment of chronic pyelonephritis is in fact aimed at producing a non-acidotic internal environment of the body.<sup>9, 41-43</sup> According to recent reviews on hypertension and pyelonephritis by Katz and Courdo, a significant number of patients with hypertension show varying degrees of pyelonephritis,

either pyogenic or aseptic.<sup>76</sup> Furthermore, as indicated by Miall and his associates, treatment of pyelonephritis by bacteriocidal agents does not affect the overall pattern of blood pressure.<sup>77</sup> Chronic pyelonephritis in patients with hypertension is therefore probably the manifestation of imbalanced physiological homeostasis. This line of thinking is further substantiated by the findings of experimental aseptic nephritis induced by the injection of large doses of adrenal DOCA to rats by Selye.<sup>78</sup>

According to Selye's concept of the general adaptation syndrome,<sup>78</sup> a "stressor" acting on the organism or any particular target tissue initiates "alarm reaction" through excitation of the sympathetic nervous system and the adrenal medulla. Following the alarm reaction the initial phase of the body defense mechanism begins as the "stage of resistance." The "stage of resistance" is caused by a rise in adrenocorticotropin leading to adrenal secretion of glucocorticoids, and for a brief time mineralocorticoids as well. The mineralocorticoids tend to localize this stressor agent by enhancing inflammatory reaction and eventually building up fibroblastic barriers. When the stress is prolonged, the action of the mineralocorticoids tends to establish pathologic changes characteristic of the "diseases of adaptation" in which Selye has included all the mesenchymal and degenerative vascular diseases. Whether or not an acute "alarm reaction" will eventually be followed by the diseases of adaptation depends, among other things, on the magnitude of the glucocorticoid secretion. Glucocorticoids, represented mostly by cortisol, replenish depleted carbohydrate stores and protect cells against many of the injurious effects of the reaction to the stressor. Therefore, the injection of cortisol minimizes inflammatory responses and subsequent tissue degeneration, as demonstrated by Selye.<sup>78</sup>

The injection of artificial hormones is, however, unnatural, and it has been clinically proven that in most cases such drugs, while temporarily counteracting effects from stressors, do not produce physiological harmony. On the other hand, orthodox acupuncture allows the reestablishment of a physiological equilibrium without drugs.<sup>54, 70, 71</sup> The beneficial effect of acupuncture for the treatment of chronic inflammatory diseases is therefore probably due to its effect on normalizing internal environmental factors through the adjustment of the autonomic nervous system and the endocrine system as well.

The mechanism of the action of acupuncture therapy as related to many other conditions has been studied and reported by many investigators. However, the scope of this article does not allow



the authors to elaborate further. The reader is referred to the appended references.<sup>24, 28, 31, 32, 34, 40, 49, 51, 54, 68, 79-83</sup>

Some attempts were made in the preceding pages to explain the mechanism of action of acupuncture, but the real significance cannot be displayed sufficiently unless the fundamental principles of Oriental medicine are understood, and subsequently its unique diagnostics and therapeutics are learned.

In the traditional Oriental medicine, disease is thought to be a state of imbalance in homeostasis, considering a diseased individual as a whole in relation with internal and external environments. Therefore, emphasis is placed on the understanding of diseased individuals rather than isolated diseases in certain organs, cells, or body fluids.

In Western medicine, a diagnosis is made with the aid of various instruments and chemicals and then a method of treatment appropriate to the diagnosis is selected. On the contrary, in Oriental medicine the method of treatment cannot be selected only by diagnosis, however precise its scientific determination. Of course, scientific examination prior to therapy is sometimes useful to determine the method of treatment or the course of the disease. Such examinations, however, are not essential except where the diagnosis coincides with the signs of the disease. This characteristic key point is the very heart of Oriental medicine.

This, however, is not meant to imply that examination with scientific instruments and chemicals are useless and should be rejected. It means that in Oriental medicine there is a complete system with which, using the physical senses rather than other aids, the signs of a disease can be determined quite accurately. The four basic diagnostics in Oriental medicine are inspection, auscultation, questioning, and palpation. In Oriental medicine the purpose of diagnosis is to evaluate the state of imbalance between the closely interrelating internal organs. Therefore, more emphasis is placed on detecting functional than anatomical abnormalities. In this regard, simple yet very important signs, such as referred pain or referred muscle rigidity, are carefully evaluated. Examination of the face, ear, tongue, and pulse often discloses very important information for the evaluation of the functional state of internal organs.

The outline of this system can be expressed as follows: The first purpose of the examination is to establish the location of the disease. It would seem that Oriental and Western medicine coincide on this point, but the locations of the diseases in the organs, which may show some resemblance, are fundamentally different. The location, in Western medicine, is taken as the place where patho-

logical changes and symptoms are most evident. For example, when pathological changes are seen in the respiratory tract, the disease is called a respiratory tract ailment; when in the digestive tract, a digestive tract ailment. The specific disease is then determined. For instance, pleurisy, pneumonia, bronchitis, asthma, or pulmonary tuberculosis may be identified in the lungs; hyperacidity, ulcer, carcinoma, or gastroparesis in the stomach.

In sharp contrast to Western medicine, the disease in Oriental medicine is not assigned to isolated individual organs. In its essential points the human body has three main divisions: The external area consisting of the surface of the body, the internal area consisting of the deep parts, and the intermediate area lying between the former two. These three divisions roughly correspond to, although are not identical with, embryological tissue of ectodermic, mesodermic, and entodermic origin. These three layers are further subdivided into various organ systems, each maintaining close relationship with others, and are known as an interconnecting system. When such stress agents as an external chill, injury, fatigue, microorganisms, or the like, form the basis for disorder, examination is used to determine the focal area of pathology in the interconnecting system. That is, the disease is localized according to its presence in a relatively external, internal, or intermediate area. Continuing in this line, the existing pathological change or its classification does not necessarily constitute the basis for treatment. In addition to localizing the disease, it is necessary to establish its nature, the viewpoint of which also varies greatly from Western medicine.

Oriental medicine employs the terms active (+), passive (-), vitality (+), and debility (-) to describe the nature of diseases. In the case of active (+), the nature is very productive, with a strong inflammatory tendency, characterized by hyperemia, fever, pain, and swelling. In passive (-), the nature tends to be latent with few symptoms of inflammation. Vitality (+) is that condition where the physical and mental energy required to contain and expel pathogenic processes is sufficient, and the faculties of defense response and restoration are at work. Debility (-) is that condition where the physical and mental energy required to contain and expel pathogenic processes is insufficient.

Applying these terms, diseases are divided into active (+) and passive (-) and further subdivided into active vitality (+) (+), active debility (+) (-), passive vitality (-) (+) and passive debility (-) (-). In the physiologically healthy person, all organs in the body exist in a state of organic

and mutual interdependence, each maintaining its separate function, yet exerting influence on another, and adjusting to the active (+) and passive (-) fluctuations of natural harmony. In the case of visceral diseases, examination through inspection, auscultation, questioning, and palpation, determines in which organ vitality (+) or debility (-) is manifested and whether the state of non-physiological active (+) = passive (-) exists. A pathologically unbalanced situation of the affected organ is then corrected through reduction (-) acupuncture for a vitality (+) disorder, and stimulation (+) acupuncture for a debility (-) disorder.

Understanding of this concept of Oriental medicine may not be too difficult if the student of Western medicine considers the similar concept of the antagonistic action of sympathetic and parasympathetic nervous systems, the functional relationship between the pituitary and its target organs, or the acid-base balance of body fluid. Ancient Chinese physicians expressed this concept of physiological homeostasis using such broad terms as Yin and Yang, with Yin, the female element, possessing all the passive properties, and Yang, the male element, the active qualities. Using the concept of Yin and Yang, they had explained remarkably well the mechanisms of physiological homeostasis. To the ancient Chinese, the parasympathetic nervous system and adrenal were Yin, and the sympathetic nervous system and pituitary were Yang in their functional relationship.

In the traditional Oriental medicine, acupuncture therapy occupies an important place in its therapeutic regimens. Other therapies to be employed in conjunction with acupuncture are dietary therapy, fasting therapy, herb therapy, Yoga therapy, hydrotherapy, diathermy, massage therapy, psychotherapy, surgery, and health education.<sup>7, 9, 41-43, 84, 85</sup>

However, all of these therapies are used only to assist patient's innate healing power in accordance with nature's health principles.

Many patients, when attacked by disease, do not take the trouble to search for the cause of their illness. Their chief anxiety is to rid themselves of pain and inconvenience. So they resort to various kinds of drugs, whose real properties they know little, or they apply to a physician for some remedy to counteract the result of their misdoing, but with no thought of making change in their unhealthful habits. To these patients, the responsible physician of Oriental medicine teaches the importance of pure air, sunlight, rest, exercise, proper diet, temperance, happy home, peace, and

harmony. Therefore, in acupuncture therapy, all of these beneficial effects act in synergy to treat the patient as a whole. The responsible physician of the traditional Oriental medicine is not a mere therapist, but a guardian of health. He teaches his patients right habits of living and nature's health principles.

In China, acupuncture anesthesia is used extensively for major surgeries. Dimond recently reported his observation of acupuncture anesthesia administered on patients undergoing thyroidectomy, thoracotomy, craniotomy, and laparotomy.<sup>101</sup> His reports as well as ones from Europe indicate that the success rate of this type of anesthesia is quite high ranging somewhere in the neighborhood of 90-95 per cent.<sup>44-47, 101</sup> However, the physiological basis of acupuncture anesthesia is not clearly understood at present. There are, however, several theories to explain the mechanism of action in acupuncture anesthesia. One of the most popular theories is the gateway control theory of pain proposed by Melzack and Wall.<sup>100</sup> According to the theory, acupuncture needle stimulation, mainly transmitted by the myelinated nerve fibers, seems to close the hypothetical gateway of pain in the substantia gelatinosa of the spinal cord. Recently, Man and Chen postulated the existence of another gateway of pain in the thalamus. Shealy demonstrated that electrical stimulation of peripheral nerves and dorsal column fibers of the spinal cord could produce anesthesia.<sup>91-97</sup> Clinical application of his procedures seems to be very encouraging. However, it is to be noted that acupuncture is capable of producing anesthesia even without the application of electronic current. For that reason, the hormonal theory of inhibition is equally attractive. It is well known that sympathin released at the sympathetic nerve endings inhibits some of the effector structures innervated by sympathetic fibers, and that acetylcholine liberated by some of the parasympathetic endings can cause similar inhibition. It is demonstrated by Grashchenkov that the blood content of sympathin and acetylcholine can be regulated by adjusting the amount of acupuncture stimuli as well as the sites of its application.<sup>68</sup> Therefore, it is not unreasonable to postulate that the excitability of sensory neurons of the central nervous system could also be regulated by adjusting the amount of hormone capable of inhibiting ganglion cell excitability. Although the presence of such a hormone needs to be proven, careful review of the ancient Chinese literature strongly suggests this possibility.<sup>1, 43</sup>

## SUMMARY

Acupuncture is an ancient Chinese therapy to treat disorders of internal organs through stimulation of the body surfaces by needles.



It appears the acupuncture is most effective for the treatment of functional disorders of internal organs. The beneficial effect of acupuncture appears to be due to its effect on the adjustment of function of the autonomic nervous system and the endocrine system as well. In effect, it seems to act to restore body's natural defenses against stressors.

The traditional Oriental medicine holds the view that, as human phenomena of life are governed by the universe and nature, the promotion of health as well as the treatment of diseases should be done in accordance with the principles of nature. In the traditional Oriental medicine, disease is thought to be a state of imbalance of homeostasis, considering a diseased individual as a whole in relation with his internal and external environments. Therefore, emphasis is placed on the understanding of diseased individuals, rather than isolated diseases in certain organs, cells, or body fluids. Western medicine has hitherto dealt mainly with the material structure and the molecular property of the organism. In the Orient, however, many scholars have studied the immaterial world and kinetic structures of each phenomenon for several thousand years. Objects are viewed in terms of energetics and function from the standpoint of unity, synthesis, and totality. The pathology is studied from a synthetic point of view. It is upon this foundation that Oriental medicine is based.

Widespread use of acupuncture anesthesia in major surgery in China is a relatively recent development. Physiological basis for acupuncture anesthesia is not clearly understood at present. However, the gateway theory and/or the hormonal theory of pain inhibition are presented. ★★

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The editors neither endorse this paper nor condemn it. Because of the wide publicity given acupuncture at the moment, it was considered to be of general interest.

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## ANSWERS ON TEST PAPERS

"A census taker is a man who goes from house to house increasing the population. . . . My favorite composer is Opus. . . . The Pony Express allowed a person to ship Shetland ponies by mail. . . . The United States is separated from Mexico by the Real Brandy. . . . A Conservative is a kind of greenhouse where you look at the moon. . . . Beethoven wrote music even though he was deaf. He was so deaf he wrote loud music. He expired in 1827 and later died from this. . . . A Scout obeys and respects all duly constipated authorities."

—Mississippi Educational Advance

# Methaqualones "Heroin for Lovers"

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ON THE STREET they are known as Quales . . . Soaps . . . Ludes Love Pills . . . the hottest drug going. After all, they aren't addicting, they take away all your troubles, they give a great body feel, and unlike heroin, which puts you out of the scene entirely, they are great for lovin'. If you don't believe it, ask anyone in the drug scene. The best part of all is that they are easy to come by legally. All you need is a script from your family physician and you can get it legally . . . refill it as often as you want without any problem. After all, it isn't even mentioned under the Drug Abuse Control Act of 1970. What more could any "drug-ger" ask for?

What is this great panacea of the drug world, this heroin for lovers? It is Methaqualone, first introduced to the United States in 1965 by the William H. Rorer Co. under the trade name Quaalude. Since that time many other pharmaceutical companies have jumped on the band wagon and we now have many Methaqualone products . . . Parest, Sopor, Somnafac, and even some "up and down" combinations of Amphetamine and Methaqualone such as the Biphetamine T. Methaqualone is a 2,3-disubstituted quinazolinone . . . 2 methyl-3tolyl-4(3H)quinazolinone. It was synthesized in India in 1955, worked its way to England and then to the United States.

Seven months after it was introduced in Great Britain, there was a marked increase in the number of acute poisonings. Five per cent of the patients admitted to the Royal Infirmary, Edinburgh, Scotland, Poison and Treatment Center had acute overdose reactions from Methaqualone. Later this figure went as high as 15 per cent. Legitimate sales from 1965 to 1972 in the United States increased 400 per cent and are still climbing. In one eastern university, as many as 5,000 pills are reported to have been sold in a single day. There have been so many acute poisonings

and acute withdrawal symptoms from this "safe, non-addicting" hypnotic substitute for barbiturates that Mike Douglas devoted half of one of his "60 Minutes" in 1972 to the dangers and problems occurring all over the country as a result of the Methaqualones.

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*The history and etiology of the latest drug abuse epidemic, Methaqualone, is given. The author discusses valid medical uses and the qualities the drug produces in abusers. He emphasizes that the drug is being abused in Mississippi as evidenced by case reports from the Mississippi Gulf Coast Drug Abuse Center.*

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What is the truth of the matter? A professional journal advertises Methaqualone as an effective hypnotic with all of the advantages of other hypnotics and none of the disadvantages. It says, "Patients awake refreshed, alert and pleasant, fit for physical and mental activities. Headaches and other side effects are minimal." Methaqualones are not on the controlled substance list. Physicians were at first led to believe that they were safe and non-addicting and many freely prescribed them. Perhaps this thinking is due to the fact that the Methaqualone's mode of action is on a different C.N.S. site than that acted upon by the barbituric acid derivatives. Unlike the barbiturates, its action is not due to direct depression of the midbrain reticular system. High doses of Methaqualone depress the polysynaptic reflexes, with little or no effect on the monosynaptic reflexes, skeletal muscles or spinal ganglion. It raises the threshold for electrically induced seizures and produces but minor suppression of REM sleep. There is no excitation phase. It is readily absorbed by the gastrointestinal tract, transported in the plasma, and distributed in areolar tissue, liver and

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Director, Mississippi Gulf Coast Drug Abuse Center,  
Gulfport, Miss.



brain tissue. It is metabolized in the liver. As well as being a hypnotic, it has antitussive and antispasmodic properties. When taken as prescribed it is a valuable adjunct to the physician's armamentarium. Methaqualone produces drowsiness within 10 to 30 minutes, and the patient generally falls into a restful sleep which lasts approximately six to eight hours. Supposedly the patient can be awakened at any time and have full control of all faculties without adverse reaction. On paper, and as prescribed, Methaqualone is an ideal drug to use as a sedative.

Thus it has gained a reputation for being a safe substitute for barbiturates and heroin. It is readily available on the street and abusers have no difficulty in obtaining it by prescription or from the family pusher, the medicine cabinet. The reports received from other areas and interviews with clients of the Mississippi Gulf Coast Drug Abuse Center indicate that Methaqualone is one of the most desired if not THE most desired drug for nonmedical use on the street today. "Eating a couple of Quales" produces a euphoric high, a "body feel." There is no mind-altering effect such as is found with some of the abused barbiturates. Usually the abuser first becomes relaxed. His worries and cares melt away. Tingling, a pins and needles sensation, may be present along with a warm, comforting feeling. Formication is a common persisting symptom at the Mississippi Gulf Coast center. Many users claim aphrodisiacal properties; hence the street name, "heroin for lovers." Approximately an hour after ingestion, incoordination occurs, particularly of the extremities. Speech becomes slurred and slow; conversation is difficult. At this point, the abuser fights off sleep in order to enjoy the sensation he is experiencing to the fullest extent. "Luding Out" or taking 300-450 mg of Methaqualone with wine is also a popular method of abuse. Herein lies the greatest danger. The combination of alcohol and Methaqualone has accounted for most of the toxic reactions seen at the center. Because of the synergistic action of this combination, overdose, coma, and death are a great problem. Most fatal cases of large doses of Methaqualone have been in combination with alcohol.

Another reason for fatalities from Methaqualone is that the fatal dose remains constant (about 125 mg/Kg body weight) even though tolerance does develop. Eventually the fatal dose and the "euphoric" dose become dangerously close, so that a couple of drinks could tip the balance.

Coma has been known to occur following 2.4 gms of Quaalude. It is interesting to note that Methaqualone produces coma without affecting

the gag reflex and without significant alteration of pulse rate, respiration, blood pressure, or pain response. This is of benefit when using Methaqualone to potentiate analgesic action of pre-anesthetic medication, yet it complicates the evaluation of a patient's homeostatic status. Two of our patients would revive momentarily and then slip back into coma. The recommended management of overdose includes prompt evacuation of gastric contents, maintenance of adequate ventilation and supportive measures. Dialysis may be helpful. It is important to remember that analeptics are contraindicated.

Adverse physiological reactions to Methaqualone abuse have been noted in clinical studies. These include irritability, headache, restlessness, anxiety, hangover and torpor. Dermatological symptoms such as skin eruptions, urticarial reactions, diaphoresis, bromhidrosis and exanthema have been noted.

An interesting reaction to Methaqualone was noted in a clinical study of a polydrug abuser at the Mississippi Gulf Coast Drug Abuse Center. A childhood stutter which had been overcome and was not otherwise in evidence would reoccur following abuse of Methaqualone. Within 24 hours after discontinuing Methaqualone, the stutter would disappear until the next episode of Methaqualone abuse.

#### METHAQUALONE DEPENDENCY

Besides having tolerance and overdose potential, Methaqualone also produces psychological and physical dependency. Madden reported four cases of physical dependency as far back as 1966, and we have had three cases at the Gulf Coast center in the past year. Therefore, evaluation of the patient should be considered as to the addiction-prone potential before the physician prescribes Methaqualone. Warnings of dependency should be given and the dangers of combination with alcohol should be emphasized. Methaqualone is not recommended for children under 15 years of age nor during pregnancy.

As with any addictive substance, upon discontinuance of Methaqualone, withdrawal syndrome occurs. Schnoll et al describes three cases where subjects were taking from 600 mg to 3,000 mg of Methaqualone daily. When the drug was withdrawn, abdominal cramps, headaches, insomnia, anorexia, and nightmares were experienced. Ewart and Priest found delirium tremens to be the main effect of withdrawal from Methaqualone. Neurological signs can include positive Babinski, deep tendon reflex increase and myoclonia. Cardiovascular complications include acute cardiac failure, tachycardia and increased vascular permeability. At the center we have noted coarse tremors

and antisocial behavior to be common. Kato reported that antisocial behavior was the chief complaint of withdrawal from Methaqualone. He noted 7 per cent had convulsions and 9 per cent had symptoms of delirium. Swatzburg describes a 32-year-old man who survived a grand mal seizure resulting in multiple fractures of the facial bones. Because of these possibilities upon withdrawal of Methaqualone, it is important for the physician to know that one should not withdraw without a period of graduated detoxification. As with barbiturates, "cold turkey" can produce convulsions and death.

One method of detoxification is to decrease the daily dose of the abuser by 150 mg at three day intervals. Another method reported is a decrease of 150 mg daily. Another possibility is to hospitalize the patient and substitute a long acting barbiturate for the Methaqualone and proceed with barbiturate withdrawal while the patient is in the hospital.

As with any addicting drug, treatment of the physical dependency is not enough in itself, and

it is important to take note of and treat the psychological dependency as well. This is perhaps the most difficult part and must be an individualized program. ★★★

1202 Broad Avenue (39501)

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## HOW TO REACH A NONDOCTOR

It was not a doctor I was calling: It was a lawyer or an insurance representative or a mechanic. Anyway, he didn't answer. So I rang the "if no answer, call" number.

They were right. Nobody answered.

—*Nebraska Medical Journal*



# Radiologic Seminar CXXXIII: Intermittent Duodenal Obstruction— A Case Report

WILLIAM C. YARBROUGH, M.D.  
Greenville, Mississippi

A 26-YEAR-OLD patient was admitted on Sept. 7, 1972, with a two month history of intermittent vomiting, abdominal pain, intermittent constipation and diarrhea. The patient had been only on oral intake of cokes. Her height was 5' 6"; weight, 76 pounds.

On admission, the first film revealed abdominal distention; the stomach was markedly dilated, and the duodenum was markedly dilated. Five thousand cc. fluid was evacuated immediately. No gastrografen passed the third portion of the duodenum. The patient was sent to her room with Cantor tube in place. Cantor tube eventually passed the third portion of the duodenum and the patient was kept on continuous suction with another smaller tube in the stomach.

On Oct. 22, 1972, the patient had an operation. There was enlargement of the first and second portions of the duodenum. The entire duodenum was freed by a Kocher maneuver. The duodenum was opened vertically and closed transversely and was freely movable beneath the superior mesenteric artery and was returned in this position. The gastrostomy tube was in place. Hyperalimentation was used and the patient continued to improve and was discharged on Nov. 16, 1972.

The last film was made on July 3, 1973, at which time the patient weighed 136 pounds and was free of symptoms.

The duodenum has received its name from being about equal in length to the breadth of 12 fingers (25 cm.). It is the shortest, the widest and the most fixed part of the small intestine and has no mesentery being only partially covered by peritoneum. Its course presents a remarkable

curve somewhat in the shape of an imperfect circle so that its termination is not far removed from its starting point.

Commencing at the pylorus it passes backward, upward and to the right beneath the quadrate lobe of the liver to the neck of the gall bladder, varying slightly in direction according to the degree of distention of the stomach. It then takes a sharp curve and descends along the right margin of the head of the pancreas for a variable distance, generally to the level of the upper border of the body of the fourth lumbar



Figure 1. Marked gastric distention.

From the Department of Radiology, General Hospital,  
Greenville, Miss.  
Sponsored by the Mississippi Radiological Society.



Figure 2. Tube passed into the stomach.



Figure 3. Tube passed into distal ileum relieving obstruction.

vertebrae. It now takes a second bend and passes from right to left across the vertebral column having a slight inclination upward, and on the left side of the vertebral column having a slight inclination, it ascends for about 2.5 cm. and then ends opposite the second lumbar vertebra in the jejunum. As it unites with the jejunum it turns abruptly forward forming the duodenal-jejunal flexure.

From the above description it will be seen that the duodenum may be divided into four portions, superior or bulb, descending or second portion, horizontal or third portion and ascending or fourth portion. The horizontal portion is the one that concerns us here. It is crossed by the superior mesenteric vessels and the mesentery. Its front surface is covered by peritoneum except near the middle line where it is crossed by the superior mesenteric vessels. Its posterior surface is uncovered by peritoneum except toward its left extremity where the posterior layers of mesentery may sometimes be found covering it to a variable extent. It rests upon the right crus of the diaphragm, the inferior vena cava and the aorta. The upper surface is in relationship with the head of the pancreas. Of extrinsic obstructions the most common and the most important is volvulus of the entire midgut. Volvulus of this



Figure 4. Appearance of stomach and duodenum after surgical correction of bands.



type is due to faulty rotation of the midgut and faulty fixation of its mesentery.

Failure of rotation, incomplete rotation and reverse rotation all predisposed to volvulus of the midgut around the central axis of the superior mesenteric artery with compression and obstruction of the third portion of the duodenum. It may occur before birth, soon after birth, months or years after birth or may never occur. Volvulus of the midgut is a dynamic lesion and there may be frequent spontaneous remissions and relapses

in a course of a few weeks or several years with a highly fluctuating clinical picture. Chronic fluctuating congenital obstruction at the end of the duodenum is often due to congenital compression. Peritoneal bands produce transitory obstruction with severe vomiting which may be subsided completely before another attack. In a chronically vomiting patient, mega duodenum is an indication for exploratory surgery and removal of the offending peritoneal structures or bands. ★★★

General Hospital (38701)

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### ALL HIS WORLDLY GOODS?

She was 16, he was 17, and the parents were opposed to the wedding. When the minister asked the youthful bridegroom to repeat after him, "With all my worldly goods I thee endow," his mother nudged her husband and whispered, "There goes his motor scooter."



# The President Speaking

## “Why Belong to AMA?”

ARTHUR A. DERRICK, JR., M.D.

Durant, Mississippi

A NEW PAMPHLET will be mailed to all dues-paying AMA members this month identifying and describing the tangible benefits of membership, listing such things as low-cost insurance programs, retirement plans, publications, and so forth. I can't remember seeing any such list enumerating the intangible benefits.

It made me think . . . Damn! There must be a lot of them, a lot more than just belonging to the parent organization, more than just getting the JOURNAL every week, more than sending in a sizable check every year (I just paid mine!) to, among other things, support a lobby in Washington to present our side to the steadily widening wedge of government involvement in medical affairs.

I believe that word “our” is the touchstone. When each of us made our decision to enter this great demanding profession, whether as a stripling tentatively dissecting a turtle's innards, or as a gangling adolescent with the acrid acid scent of chemistry lab in his nostrils, or even as an unsure collegian confronted with seemingly innumerable avenues of effort, we, perhaps unknowingly, joined a pilgrim band, long established, dedicated to easing the pains and sufferings of humanity. Right then we made our commitment and, unsolicited, joined this confraternity of help and succor to our fellow wanderers.

It is easy to rationalize a totally independent existence. After the long and arduous training we all endured and the uncertainties of setting up practice, it is only natural that we should welcome the benefits of an established practice, both monetary and ego-satisfying. It is also easy to forget that we owe an enormous debt to our predecessors, our preceptors and our professional colleagues.

We are all American. We are all medical. And we sure as hell need to associate, now as never before. ★★★





## Mississippi's Participation in the SSA Disability Program

UNDER THE PROVISIONS of the Social Security disability program, the nation's largest disability plan, a worker under 65 years of age can receive monthly benefits if he or she becomes unable to work due to a mental or physical impairment that has lasted—or is expected to last—at least 12 months or is expected to result in death.

More than 96 million workers can count on monthly cash benefits in the event of such severe and extended disability. In addition, the dependents of these workers are also eligible for monthly benefits. Over 1.8 million workers and 1.4 million dependents are now receiving disability benefits at the rate of almost \$5 billion a year because someone in the family—usually the breadwinner—is disabled.

Currently, 28,773 disabled workers in Mississippi are collecting \$4,464,991 a month in benefits. In addition, 6,585 wives or husbands of disabled workers and 21,912 children of disabled workers in the state are receiving \$291,040 and \$853,342, respectively.

The latest year for which tabulated data is available showing disabled worker diagnostic patterns by state is 1970. Disabled workers in Mississippi who began receiving benefits in that year constituted 5,086 of the 350,384 new beneficiaries nationwide.

Table 1 compares the frequency of diagnostic

groups in Mississippi with the U. S. overall. It shows that diseases of the circulatory system comprised the largest diagnostic group in the country in 1970. Diseases of the musculo-skeletal system and mental disorders, including psychoneurotic and personality disorders, were the second and third largest diagnostic groups, respectively. All states do not, however, follow this pattern.

Of these overall diagnostic groups, the most prevalent primary diagnosis in both Mississippi and the nation in 1970 was chronic ischemic heart disease. The state recorded 1,055 cases that year. The nation's second most common primary diagnosis, schizophrenic disorders, accounted for 189 cases in Mississippi. Following these, in order of decreasing national prevalence, was osteoarthritis and allied conditions, with Mississippi reporting 256 cases, followed by emphysema with 149 cases. There were 235 cases of displacement of intervertebral disc in Mississippi; 150 cases of diabetes mellitus, and rheumatoid arthritis and allied conditions accounted for 152 cases in the state that year. Cerebrovascular disease, listed eighth among the most prevalent primary diagnoses in 1970, recorded 185 cases in Mississippi; malignant neoplasm of trachea and lung 79 cases; and neuroses ranked tenth with 134 cases.

In making disability determinations, the agency uses medical criteria developed by the Social Se-

TABLE 1  
SOCIAL SECURITY WORKER DISABILITY ALLOWANCES, 1970—  
DIAGNOSTIC GROUPS

Diagnostic Group	U. S.		Mississippi	
		PER CENT		PER CENT
Diseases of the circulatory system . . . . .	108,906	31.1	1,789	35.2
Diseases of the musculo-skeletal system . . . . .	52,086	14.9	939	18.5
Mental, psychoneurotic, and personality disorders . . . . .	38,406	11.0	517	10.2
Neoplasms . . . . .	36,095	10.3	363	7.1
Accidents, poisonings, and violence . . . . .	28,231	8.1	365	7.2
Diseases of the respiratory system . . . . .	24,254	6.9	258	5.1
Diseases of the nervous system and sense organs . . . . .	22,575	6.4	249	4.9
Allergic, endocrine system, metabolic, and nutritional diseases . . . . .	13,141	3.8	232	4.6
Diseases of the digestive system . . . . .	9,051	2.6	99	1.9
Infective and parasitic diseases . . . . .	8,760	2.5	133	2.6
Other . . . . .	8,875	2.5	142	2.8
Total . . . . .	350,384	100.0*	5,086	100.0*

\* Figures may total more or less than 100.0 due to rounding.

curity Administration to insure uniform evaluation of all applicants regardless of where they live and to help simplify and speed the decision process. The complete criteria, including the medical findings listed by body system, are contained in a handbook designed especially for professionals who come in contact with the disabled population. The handbook may be obtained from the Disability Determination Unit, P. O. Box 1271, Jackson 39205.

E. P. RAWSON  
Disability Determination Unit  
Jackson, Miss. 39205

JOIN



TODAY

SBH Places 6 Drugs  
in Schedule III

The Mississippi State Board of Health in regular session on Aug. 9, 1973, voted that the following substances be placed in Schedule III of the Mississippi Controlled Substances Act:

- benzphetamine* (marketed under the name of Didrex by the Upjohn Company);
- chlorphentermine* (marketed under the name of Pre-Sate by Warner-Chilcott Laboratories, Division of the Warner-Lambert Company);
- clortermine* (a new drug soon to be marketed under the name of Voranil by the USV Pharmaceutical Corporation);
- mazindol* (a new drug soon to be marketed under the name of Sanorex by Sandoz Pharmaceutical, Division of Sandoz-Wander, Inc.);
- phendimetrazine* (marketed under a variety of names by at least 20 different companies, the most prominent of which is Plegine by Ayerst Laboratories);

and that

*fenfluramine* (a new drug to be marketed under the name of Pondamin by A. H. Robins Company)

be placed in Schedule IV, in order to conform to the Federal Controlled Substances Act.





## THE LITERATURE

### Book Reviews

**Critical Surgical Illness.** Edited by James D. Hardy, M.D. 679 pages with illustrations. Philadelphia, Pa.: W. B. Saunders Company, 1971.

*Critical Surgical Illness* represents a series of detailed discussions by well known authors of subjects frequently encountered by today's active surgeon. The authors have been carefully selected by the editor and are readily recognized for their leadership in their respective fields.

Each chapter usually includes pathophysiology, diagnosis, treatment and prevention. Many chapters deal with a general subject such as pulmonary insufficiency, shock, oliguria, wound dehiscence, postoperative bleeding, etc. while others such as suppurative cholangitis, Z-E tumors, infected arterial grafts, etc. are discussed as specific entities.

While each subject should be interesting to today's surgical practitioner, the opening chapter on post-traumatic pulmonary insufficiency by Dr. Frances Moore was especially timely and interesting. Many of the authors, while being thorough, are concise making their subject more readily useful for reference.

This excellent book should be of value as a practical reference for each general surgeon engaged in a busy surgical practice today.

R. S. CALDWELL, M.D.  
Tupelo, Miss.

**Cancer Diagnosis in Children.** By L. D. Samuels, M.D. 131 pages with illustrations. Cleveland, Ohio: The CRC Press, 1972. \$26.00.

This book is concerned with the general and specific approaches to the diagnosis of cancer in children—the number one fatal disease in the pediatric age group. Principal emphasis is placed on the available but ever-changing information regarding diagnostic nuclear medicine and tumor detection.

Though the book devotes 67 of its 131 pages to radionuclide choices and techniques and x-ray photographic scan illustrations (beautifully demonstrated and with lesions clearly defined), the rapid evolution within this field "dates" this material at about 1971. On the other hand, the author is to be complimented for the logical and

lucid details involving the rationale for the use of Technetium-99m, Mercury-197, Strontium-87m, I-131 Rose Bengal, and other isotopes in demonstrating neoplasms.

Perhaps one of the strongest points of the book is the very first chapter which deals with the general history and physical examination of the child suspected of having cancer. The author's approach to a good physical examination in the pediatric patient is worth a review by any practicing physician.

I certainly would recommend this book as a reference for those who are interested in or plan to utilize radioisotope scanning techniques (with the obvious assistance of persons trained in their use) in diagnostic evaluation of children with suspected malignancy. Though some areas of pediatric oncology are obviously slighted, the primary purpose of the book is to acquaint physicians with the distinct usefulness and apparent safety of these radioactive materials.

JOHN D. MCEACHIN, M.D.  
Meridian, Miss.



## PERSONALS

GODFREY E. ARNOLD and MYRON W. LOCKEY of Jackson and UMC attended the meetings of the American Academy of Ophthalmology and Otolaryngology in Dallas.

H. B. BARNES of Hattiesburg has received a community service award from the Petal Optimist Club noting his long service as team physician for the Petal High School Panthers.

ALFRED W. BRANN, JR., of Jackson and UMC has been elected president of the 14-state Southern Perinatal Association.

HUGH P. BROWN announces the opening of his offices for the practice of orthopaedic surgery at Suite 510, St. Dominic Medical Offices, 971 Lakeland Drive in Jackson.

JOE BUMGARDNER, RAY LYLE and GEORGE WALKER have set up their respective practices in Starkville. Dr. Bumgardner is a general surgeon (offices located at 517 University Drive); Dr.

## PERSONALS / Continued

Lyle a pediatrician; and Dr. Walker an ophthalmologist.

CLYDE BURGESS and BENJAMIN NUTT began the practice of medicine in Holly Springs this month. Dr. Burgess will have his offices in the Marshall County Hospital, and Dr. Nutt's office will be in the Wallace Building.

CHARLES CACCAMISE and JAMES G. THOMPSON of Jackson and JIM M. BROCK of McComb were among 21 former presidents of the Louisiana Dermatological Society recently honored in New Orleans at a special meeting of the organization.

JOEL T. CALLAHAN announces the association of A. GARY BOONE (internal medicine and nephrology) and THOMAS H. GREER (internal medicine and cardiology) at the Internal Medicine Clinic, 1504 20th Avenue in Meridian.

CARLOS M. CHAVEZ of Jackson was visiting lecturer for the Sociedad Regiomontande De Cardiologia meeting in Monterrey, Mexico.

ROBERT DONALD of Pascagoula and JAMES THOMPSON of Moss Point have retired as Directors of the Pascagoula-Moss Point Area Chamber of Commerce.

MIGUELITO FERNANDO has joined the practice of VIRGINIA TOLBERT at Ruleville. Dr. Fernando is specializing in obstetrics and gynecology.

The Surgical Clinic, P.A., and Drs. Meena and Tyler, P.A., of Jackson announce that the two professional corporations have merged and will hereafter practice under the name of the Surgical Clinic, P.A., at Suite 400, Medical Plaza Building, 1600 North State Street, Jackson 39202. Composing the group are JAMES C. GRIFFIN, JR., J. HARVEY JOHNSTON, JR., THOMAS L. KILGORE, JR., MARTIN H. McMULLAN, ALBERT L. MEENA, W. COUPERY SHANDS, and HENRY B. TYLER.

HAROLD K. HUDSON was guest speaker at a meeting of District 25 Nurses Association in Tupelo. Dr. Hudson discussed cancer of the larynx.

DONALD T. IMRIE of Vicksburg attended the New York Academy of Sciences Conference on "Electrically Mediated Growth Mechanisms in Living Systems."

MICHAEL E. JABALEY of Jackson and UMC attended a "Cancer of the Head Symposium" in Baltimore recently. Dr. Jabaley has also been named to the Plastic Surgery Research Council.

His research interests are head and neck cancer and surgery of the hand.

A. JERALD JACKSON has associated with the department of internal medicine of the Hattiesburg Clinic Professional Association in Hattiesburg.

JOHN F. JACKSON of Jackson and UMC spoke at the Blackford Memorial Lectures of the Grayson County Medical Society in Denison, Tex.

W. ARTHUR JONES announces the opening of his office for the practice of cardiology at Suite 226, Hinds Professional Building, 1815 Hospital Drive in Jackson.

T. D. LAMPTON and FRANCIS S. MORRISON of Jackson attended the American College of Physicians Southeastern Regional meeting at Sea Island, Georgia.

FRANK L. LEGGETT of Bassfield recently held an art show of his work at the Lincoln County Public Library.

MYRON W. LOCKEY of Jackson and UMC attended the Baltimore symposium on cancer of the head and neck.

W. R. LOCKWOOD of Jackson presented a paper at the 8th International Congress of Chemotherapy in Athens, Greece.

LAWRENCE B. McEACHIN announces the opening of his office at 1302 Twenty-first Avenue in Meridian. Dr. McEachin's practice is limited to diseases of the skin.

ANDIN C. McLEOD, JR., has joined the staff of the Hattiesburg Clinic. Dr. McLeod is an orthopaedic surgeon.

REUBEN P. MORRIS of Moss Point was presented an award by the Moss Point Non-Partisan Voters League in recognition of his 20 years of service to the community.

LUCAS O. PLATT has associated with JOHN P. ELLIOTT, JR., JAMES O. GORDON and JOHN W. EVANS for the practice of urology at 605 Garfield Street in Tupelo.

ALANSON BROWN SMITH announces the opening of his new offices for the practice of internal medicine at St. Joseph Medical Plaza, 5002 Highway 39 North in Meridian.

EDWARD STEWARD has associated with DECK STONE at South Panola Hospital in Batesville for the general practice of medicine.

AKIO SUZUKI of Jackson and UMC spoke at the



Society of Thoracic and Cardiovascular Surgery in Japan and presented a paper at the International College of Surgeons meeting in Spain in September.

R. D. WARD announces his association with the Van Winkle Medical Clinic, 4304 Highway 80 West in Jackson for the general practice of medicine.

DAVID G. WATSON of Jackson and UMC was elected president of the Southeastern Pediatric-Cardiology Society for 1973-74.

GEORGE W. WHARTON has associated with GUY T. VISE, JR., of Jackson for the practice of orthopedic surgery and rehabilitation at Suite 425, St. Dominic Medical Offices, 971 Lakeland Drive.

DAVID B. WILSON of Jackson and UMC attended a September meeting of the Joint Commission on Accreditation of Hospitals in Chicago.



## THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

*Nov. 5-9, 1973*

### UROLOGY INTENSIVE COURSE

University Medical Center, Jackson

Nov. 5-9, 1973, beginning at 8:30 a.m.

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

#### Coordinator:

W. Lamar Weems, M.D., associate professor of surgery and director of division of urology, The University of Mississippi School of Medicine

The emphasis of this course will be on practical urology as it relates to the nonurologist. The latest concepts and practices in common urologic diseases will be presented.

*Nov. 12-16, 1973*

### CARDIOLOGY INTENSIVE COURSE

University Medical Center, Jackson

Nov. 12-16, 1973, beginning at 9:00 a.m.

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

#### Coordinator:

James R. Galyean, M.D., assistant professor of

medicine, The University of Mississippi School of Medicine

The family physician will familiarize himself with current concepts in bedside diagnosis of heart disease. Review of the physical diagnosis of various forms of heart disease using such aids as pulse tracings, phonocardiograms, electrocardiograms, x-rays, and hemodynamic data in illustration will be covered. A cross-section of cardiac diagnoses will be reviewed.

*Nov. 12-16, 1973*

### NEUROLOGY AND NEUROSURGERY INTENSIVE COURSE

University Medical Center, Jackson

Nov. 12-16, 1973, beginning at 8:00 a.m.

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

#### Coordinators:

Robert D. Currier, M.D., professor of medicine and co-director of the stroke unit of the Regional Medical Program

Armin Haerer, M.D., associate professor of medicine, The University School of Medicine

The content of this course will include the management of adult and children's neurological disorders. Material will be presented in seminars, discussion groups and assigned reading and rounds on the wards and clinics. Rehabilitation techniques will be included.

All of the intensive courses are offered through the University of Mississippi Medical Center, with partial support from the Mississippi Regional Medical Program, The Kidney Foundation of Mississippi, Inc., the Lilly Research Laboratories, the Bristol Laboratories, G. D. Searle and Company, and private donations. The courses are open to all Mississippi physicians. A registration fee of \$100.00 is charged.

*Nov. 26-30, 1973*

### NEWBORN SHORT COURSE FOR DOCTORS AND NURSES

University Medical Center, Jackson

Nov. 26-30, 1973

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

#### Coordinator:

Alfred W. Brann, Jr., M.D., assistant professor, department of pediatrics, and director, newborn center, The University of Mississippi School of Medicine

This course is planned for physician/nurse teams. Most of the content will be presented in joint sessions, with ample time allowed for discussion of special problems in nurseries represented by the teams in attendance. It is open to physicians involved in the care of newborns as the primary physician. There is a \$10.00 fee for physicians.

### SEMINARS

#### CURRENT CONCEPTS IN HYPERTENSION

*Nov. 28, 1973*

University Medical Center, Jackson

*Nov. 28, 1973*

Sponsored by the University of Mississippi School of Medicine, with support from G. D. Searle and Company

Coordinator:

Herbert G. Langford, M.D., professor of medicine, physiology, and biophysics, The University of Mississippi School of Medicine

This symposium will bring together nationally known experts to present new developments in treating hypertension to the family physician. Preventive cardiology, curable hypertension, Aldosterone are some of the topics to be discussed. Hypotensive therapy will be included in the program.

### FUTURE CALENDAR

*Nov. 5-9*

UROLOGY INTENSIVE COURSE

*Nov. 12-16*

CARDIOLOGY INTENSIVE COURSE

*Nov. 12-16*

NEUROLOGY AND NEUROSURGERY INTENSIVE COURSE

*Nov. 26-30*

NEWBORN SHORT COURSE FOR DOCTORS AND NURSES

*Nov. 28*

HYPERTENSION SYMPOSIUM

*May 6-9*

MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

## Chest Physicians Meet in Toronto

Physicians Denton A. Cooley, F. Mason Sones, Jr., and Eric Carlens will be among the speakers investigating heart and lung diseases during the American College of Chest Physicians annual meeting in Toronto Oct. 23-25, 1973.

Lung disease, pacemakers, cardiovascular surgery, occupational ailments and the critical and growing problem of hypertension will be weighted in a series of symposiums, scientific papers, panel discussions and other sessions.

The ACCP's 39th annual meeting will be held in the Four Seasons Sheraton Hotel. On Monday, Oct. 22, the following are scheduled: a national seminar for allied health professionals; visits to several Toronto hospitals, and evening seminars. Scientific programs will be held at each hospital.

"Complications Associated With Cardiac Drugs in the Pulmonary Patient" will be the subject of a Tuesday morning symposium. Many of the 90 papers to be presented will deal with cardiovascular surgery, and a Wednesday symposium will discuss "Recent Advances in the Diagnosis, Preventions and Treatment of Thromboembolism."

Dr. Cooley, of Houston, Tex., a pioneer in heart transplantations, will speak Wednesday morning in a session on cardiovascular surgery. Dr. Sones, of the Cleveland (Ohio) Clinic, will lecture Thursday morning on the x-ray examination of coronary circulation. Dr. Eric Carlens, of Stockholm, Sweden, will present a special lecture on treatment for lung cancer.

Hypertension, a critical health problem afflicting millions each year, will be probed in a luncheon panel entitled "Hypertension: A New Look at an Old Disease." Another luncheon panel will take a hard look at "Pulmonary Heart Disease in the Young."

For further details, contact: Miss Mary Ellen Zielinski, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611.

## Cardiac Cath Course Planned

The rapid changes in cardiac catheterization techniques and methods of evaluation will be the theme of the first postgraduate course of the 1973-74 American College of Chest Physicians calendar of meetings.

The course entitled "Ventricular Function—A



Practical Workshop," will be held in Santa Barbara, Cal., Nov. 30 and Dec. 1, 1973. This course is sponsored by the American College of Chest Physicians and the Santa Barbara Heart and Lung Institute. Course directors are Drs. John H. K. Vogel and R. Bruce McFadden.

In addition to formal presentations, the physician will take part in small group sessions, which will provide complete exposure to catheterization techniques, with emphasis on ventricular volumes, derivatives, ultrasound and the application of all of these parameters in the assessment of ventricular function. Details of how to perform the technique, as well as personal calculations of raw data, their interpretations and applications will be discussed and experimented with in the smaller groups.

For registration and fee information contact:

Director of Continuing Education, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611.

## Ophthalmology and ENT Meet Set for Israel

Symposia Medica Foundation will present an International Conference on Clinical Problems in Ophthalmology and Otolaryngology in Jerusalem, Feb. 14-24, 1974.

For further information, contact: Ms. Cynthia Soika, M.A., Projects Director, Symposia Medica Foundation, 305 East 24th Street, New York, N. Y. 10010.

### SCHEDULE OF UPCOMING NCME PROGRAMS

Here are the playing dates and upcoming programs to be distributed by The Network for Continuing Medical Education (NCME):

Nov. 5-18 *Radiologic Management of Early Cancer of the Larynx*, with Alexander D. Crosett, Jr., M.D., Director, Division of Radiation Therapy and Nuclear Medicine at Overlook Hospital, Summit, N. J.; and Charles E. Langgaard, M.D., Attending Otolaryngologist, Summit Medical Group, Summit, N. J.

*What Carotid Arteriography Can Tell You*, with Michael D. F. Deck, M.D., Associate Attending Radiologist and Associate Professor of Radiology at Cornell University Medical Center in New York.

*Natural Childbirth*, with Alfred Tanz, M.D., Attending Obstetrician and Gynecologist, Lenox Hill Hospital, and Assistant Clinical Professor, New York Medical College, New York.

Nov. 19-Dec. 2 *Hearing Loss: A Threat at Any Age*, with Merrill Goodman, M.D., Director of Otolaryngology

at Long Island Jewish-Hillside Medical Center, and Medical Director of the Long Island Hearing and Speech Center, New York.

*Tibetan Medicine: A Thousand-Year-Old Practice*, with Donald G. Dawe, Th.D., Professor of Theology, Union Theological Seminary, Richmond, Va.; and James L. Mathis, M.D., Professor and Chairman of the Department of Psychiatry, Medical College of Virginia; William Regelson, M.D., Professor and Chairman, Department of Psychiatry, Medical College of Virginia; William Stepka, Ph.D., Professor of Pharmacognosy, School of Pharmacy, all of Virginia Commonwealth University, Richmond, Va.

*Nuclear Medicine and the Community Hospital*, with Alexander D. Crosett, Jr., M.D., Director, Division of Radiation Therapy and Nuclear Medicine at Overlook Hospital, Summit, N. J.

For more information about NCME, write The Network for Continuing Medical Education, 15 Columbus Circle, New York, N. Y. 10023.

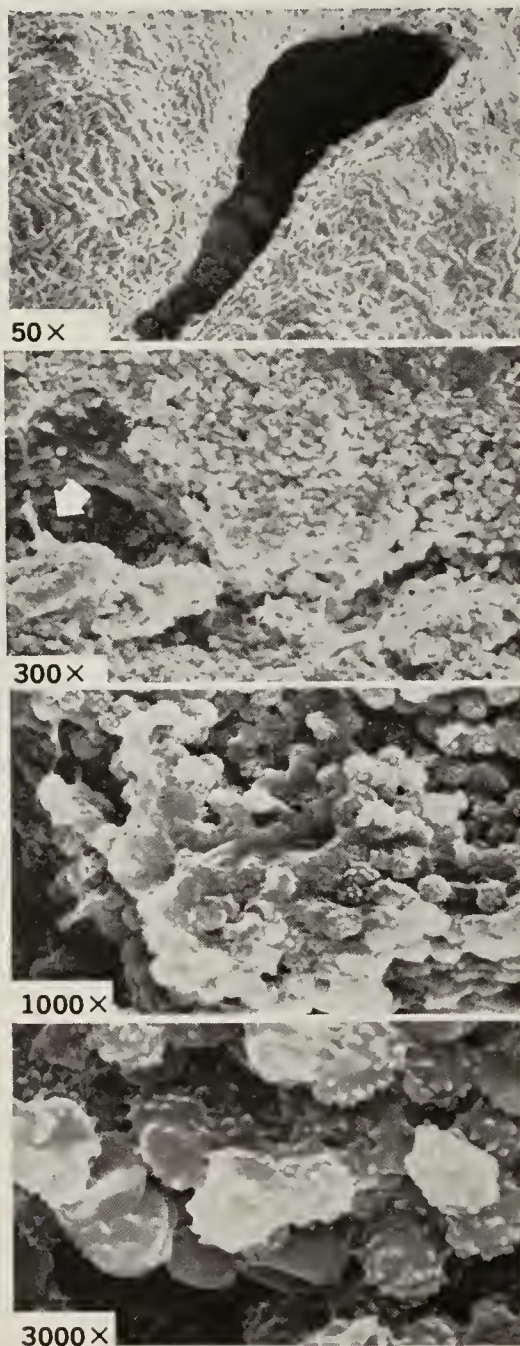


# Progress in

## Diagnosis

In these illustrations of tissue from a patient with acute cystitis, you can see the swollen and inflamed mucosa of the ureteral orifice (50X), a fibrin strand (300X), and a whitish exudate composed of polymorphonuclear leukocytes (1000X and 3000X). The photographs were taken with the scanning electron microscope (SEM) by Dr. Shirley Siew, Associate Professor of Pathology at the University of Pittsburgh School of Medicine. They come from the clinical exhibit "Scanning Electron Microscopy of Urinary Tract Infection," which won first prize in Clinical Research at the May 1972 meeting of the American Urological Association.

The scanning electron microscope promises to be extremely useful in its investigation of human pathology. In time, examination of tissue with the SEM is likely to play a significant role in the diagnosis of urinary tract infection.



### A note on the photography:

These photographs were made by the scanning electron microscope, which, like the transmission electron microscope, operates on the basic principle of exposure of tissue to a beam of electrons in a vacuum. With the SEM, electrons bombard the surface of tissue which has been given a fine coating of gold. The electrons reflect off the tissue onto a television screen, and the resulting photograph shows a three-dimensional effect. The tissue sections need not be ultrathin, so there is a minimum of handling and distortion.

Just as much an instrument of progress and just as helpful in its way has been Gantrisin (sulfisoxazole) Roche, developed and introduced a generation ago. However, there's been no generation gap over its continuing usefulness. In fact, Gantrisin, with so many years of clinical experience behind it, is still one of the most valuable drugs we have for the treatment of non-obstructed cystitis, pyelitis or pyelonephritis due to susceptible organisms such as *E. coli*. Specifically, Gantrisin provides your patient with certain important therapeutic advantages:

**References:** 1. Bran, J. L.; Karl, D. M., and Kaye, D.: *Clin. Pharmacol. Ther.*, 12:525, 1971. 2. Burke, E. C., and Stickler, G. B.: *Mayo Clin. Proc.*, 44:318, 1969. 3. Hibbard, L. T., in Bulger, M. J., et al.: *Patient Care*, 1:(3) 47, 1967. 4. Holloway, W. J.; Furlong, J. H., and Scott, E. G.: *J. Urol.*, 102:249, 1969. 5. House, T. E., et al.: *Obstet. Gynecol.*, 34:670, 1969. 6. Lampe, W. T.: *J. Am. Geriatr. Soc.*, 16:798, 1968. 7. Moffat, N. A., and Wenzel, F. J.: *Curr. Ther. Res.*, 13:286, 1971. 8. Normand, I. C. S.: *Practitioner*, 204:91, 1970. 9. Pryles, C. V.: *Med. Clin. North Am.*, 54:1077, 1970. 10. Seneca, H.; Peer, P., and Warren, B.: *J. Urol.*, 99:337, 1968. 11. Trafton, H. M., and Lind, H. E.: *J. Urol.*, 101:392, 1969. 12. Cohen, M.: *Pediatrics*, 50:271, 1972.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms.

**IMPORTANT NOTE:** *In vitro* sensitivity tests not always reliable; must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infections. Maximum safe total sulfonamide blood level, 20 mg/100 ml;

measure levels as variations may occur.

**Contraindications:** Hypersensitivity to sulfonamides; infants less than 2 months of age; pregnancy at term and during the nursing period.

**Warnings:** Safety in pregnancy not established. Do not use for Group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. CBC and urinalysis with careful microscopic



# Acute cystitis:

## Treatment

**High urinary levels** As a urinary anti-bacterial, Gantrisin (sulfisoxazole) offers your patients important advantages. Therapeutic urinary and plasma concentrations are usually reached in from 2 to 3 hours and can be maintained on the recommended 8 Gm/day dosage schedule that's convenient for almost all patients.

**Generally good tolerance** Gantrisin causes relatively few undesirable reactions, and serious toxic reactions are rare. Minor reactions are comparatively infrequent, but may include nausea, headache and vomiting. Hence, Gantrisin may usually be given even for extended periods when treating chronic or recurrent nonobstructed cystitis, pyelitis or pyelonephritis due to *E. coli* and other susceptible organisms. (See Important Note in summary of prod-



uct information.) Complete blood counts and urinalyses, with careful microscopic examination, should be performed frequently.

**High solubility** Gantrisin (sulfisoxazole) Roche is one of the most soluble of all sulfonamides, with both free and acetylated forms highly soluble in the commonly encountered urinary pH range of 5.5 to 6.5. Urine levels have been detected in

60 minutes; therapeutic levels are usually reached in from 2 to 3 hours. About 90% of a single dose is excreted in 24 to 48 hours. As with all sulfonamides, adequate fluid intake must be maintained.

**economy** Average cost of therapy is still only about 6½¢ per tablet.

**total therapy: 14 days** Recent evidence in the medical literature suggests that therapy in acute non-obstructed urinary tract infections should be continued for 10 to 14 days even if patients become asymptomatic in 2 or 3 days, as they often do.<sup>1-11</sup> However, one investigator, evaluating a 5-year study of sulfisoxazole used to treat urinary tract infection in 368 girls, found no advantage in continuing therapy more than two weeks *for a first infection*.<sup>12</sup>

**For acute, chronic or recurrent nonobstructed cystitis, pyelitis, or pyelonephritis due to susceptible organisms...**

begin with  
**Gantrisin<sup>®</sup>**  
**sulfisoxazole/Roche<sup>®</sup>**

**Usual adult dosage:** 4 to 8 tablets *stat*  
2 to 4 tablets *q.i.d.*

amination should be performed frequently.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** *Blood dyscrasias:* granulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia; *Allergic reactions:* erythema multiforme (Stevens-Johnson

syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; *Miscellaneous reactions:* Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred. Due

to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

**Supplied:** Tablets containing 0.5 Gm sulfisoxazole.



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Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

## ASIM Develops Problem-Oriented Record

The American Society of Internal Medicine will develop and distribute a major educational and research program using mixed media audio-visual systems in the area of the problem-oriented approach to medicine, according to Dr. William Campbell Felch, president of the 12,000 member society.

The ASIM has signed a letter of agreement with Synapse Communication Services, Inc. for the development, production and evaluation of learning systems to teach members how to adopt the problem-oriented medical record into their practice. In addition, ASIM will initiate a program to monitor the progress of selected society members who begin using the system, and to feed back results to new and continuing users.

The problem-oriented medical record is a tool of fundamental importance in making possible universal compatibility of medical records, an essential to standardizing communication among all members of the health care team.

Two learning systems will be developed, utilizing a mix of integrated media instructional films and workbooks. The first system will be designed to inform physicians about the problem-oriented approach to medicine. The second system will teach the basics of maintaining problem-oriented medical records. Through modern communication and educational techniques, the society hopes to launch a grass roots teaching effort to bring the program to local physician audiences across the country.

Synapse Communication Services, Inc. of Old Greenwich, Conn., selected as the company for developing both the learning systems and a follow-up research project, specializes in producing total audiovisual educational and training services for the health care profession. Synapse is a subsidiary of the J. Walter Thompson Company.

Dr. Felch said the ASIM is committed to the principles of the problem-oriented approach to medicine and would like to play a causative role in accelerating the usage of this system throughout the medical community.

Although the program will be initiated within the confines of the society, the objective is to make the programs universally available. ASIM members will be encouraged to assist other physicians in their home communities in adopting the problem-oriented system into their practice.

# Randomycin® (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS: Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea. In uncomplicated gonorrhea, when penicillin is contraindicated, 'Randomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule. 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Randomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia. 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** 'Randomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



WALLACE PHARMACEUTICALS  
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# Supplementary Security Income of SSA Will Replace Public Assistance, Title XVI

A program of "Supplementary Security Income for the Aged, Blind, and Disabled" (SSI), Title XVI of the Social Security Act, was established by Public Law 92-603 to become effective Jan. 1, 1974. It will replace the current Title XVI which permits states to combine their public assistance programs for the needy, aged, blind, and disabled. On Jan. 1, 1974, when the new program begins, federal matching for these three public assistance categories will cease. The present program of Aid to Families with Needy Children remains in effect.

The SSI program will provide each eligible individual with a minimum income of \$1,680 next year; a couple, both of whom are eligible, will have a minimum income of \$2,520. Federal funds will be added to the eligible individuals' income from other sources to bring the total to the above levels. The program will be administered by a new Bureau of Supplementary Security Income established within the Social Security Administration. However, the Social Security Administration's (SSA) Bureau of Disability Insurance, which administers the Social Security disability benefit program in operation since 1956, will be involved in the determination of eligibility for SSI benefits for blindness.

In addition to income and resource qualifications, the law requires that those seeking benefits must be residents of the United States and either citizens or aliens permanently and legally residing in the United States. For eligibility under the "aged" category, such an individual need only be 65 years of age or older. The "blind" and "disabled" categories, however, have more complex eligibility standards, involving medical evidence, and this aspect of eligibility determination will be administered by the Bureau of Disability Insurance.

Briefly, blindness or disability will be determined either by the standards now used by individual states in their public assistance programs

—Aid to the Blind and Aid to the Permanently and Totally Disabled—or by nationwide standards contained in PL 92-603.

The state standards used will be those in effect for October 1972 (when PL 92-603 was enacted) and will render those on state program rolls in December 1973 eligible for SSI benefits. This mass inclusion of all those classified as needy and blind or disabled by state standards at the end of this year will, at the outset, require little more than a transfer of the rosters of the state programs to the Bureau of Supplementary Security Income. However, these individuals will remain eligible for the SSI grant only so long as they continue to meet the October 1972 state criteria. The Bureau of Disability Insurance, therefore, will need to obtain and maintain a file of such state eligibility standards for consultation should any of these recipients' condition improve in the future.

The national standards established by PL 92-603, which must be met by all other applicants (and to the public assistance recipients should they, at some time in the future, no longer meet the October 1972 state criteria) are, briefly:

**Blindness:** Defined as central visual acuity of 20/200 or less in the better eye, with the use of a correcting lens.

**Disability:** Defined, for adults, as inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months; and for children under 18, and medically determinable physical or mental impairment of comparable severity.

The "physical or mental impairment" must be one which results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory techniques.

## MH Center Grants Go to Regions 6, 7, 11

The standards set forth for disability are essentially those for the basic Social Security disability benefit program. Both involve a two-part definition of "disability"—(a) a medically determinable physical or mental impairment; and (b) the resultant "inability to engage in substantial gainful activity." The "impairment" is a medical decision, but the "inability to engage in substantial gainful activity" is not.

In terms of the law, an individual is "disabled" only if the impairment is of such severity that he is not only unable to do his previous work, but cannot (considering his age, education, and work experience) engage in any other kind of substantial gainful work which exists in the national economy. Both the dollar amount defining "substantial" gainful activity and such occupational data as the type of work in which an applicant could engage and the availability of such work are nonmedical questions.

This point should be especially noted. Any physician examining or submitting medical histories for applicants for SSI disability benefits should remember, and inform the applicant, that the physician testifies only to the "impairment," not to "disability." If disability income is not authorized, the physician need not assume his medical judgment has been overruled, and can make clear to the applicant that the decision is not based solely on the medical evidence provided.

State agencies now have some 600 physicians handling the SSA load, about 200 fulltime. Estimates are that the caseload—for SSI and the existing disability benefit program—will more than double in 1974, from 300,000 claims handled in 1972 to three-quarters of a million in 1974, with about a quarter of this caseload expected to be in the southeastern states.

As a result, a doubling of the number of full and parttime physician staff in these agencies appears necessary. Significantly more input from physicians in private practice will also be needed. Applicants under the SSI program may tend to have less adequate medical records than those now obtaining benefits through Social Security covered employment. The Bureau of Disability Insurance is currently paying for additional medical evidence in about 20 per cent of Social Security disability applications submitted; for the SSI program, a higher percentage is expected.

Three new grants have recently been made to Mississippi regional MH-MR programs—one is a comprehensive mental health center staffing grant for Region 7 (Choctaw, Clay, Lowndes, Noxubee, Oktibbeha, Webster, and Winston counties) and the two others are mental health center initiation and development activities for Region 6 (Attala, Carroll, Grenada, Holmes, Humphreys, Leflore, Montgomery, and Sunflower counties) and for Region 11 (Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, and Wilkinson counties) which will enable these two regions to put a full-time planning staff to work to plan regional programs.

The grant awards followed the court ordered release of 1973 community mental health center funds which had been impounded by President Nixon. The successful suit to force release of the funds was filed by the National Council of Community Mental Health Centers.

The Region 7 mental health center staffing grant provides \$252,833 for the first year of center operation, beginning Jan. 1, 1974. The grant will partially support the cost of a 25-member staff to serve the 7-county area. The Region 7 Commission already has initiated limited services in the region utilizing local county tax funds.

The Region 6 grant provides \$24,955 to support fulltime planning staff for the one-year period beginning Nov. 1. The proposed study is designed to determine the mental health needs and resources of the six-county area and to propose appropriate services to meet those needs. The study places high emphasis on community involvement through special subcommittees and county-advisory committees.

The Region 11 initiation and development grant of \$43,350 provides support for the Region 11 MH-MR commission to plan for a comprehensive mental health center. The commission will contract with an areawide health planning agency—Comprehensive Health Planning, Southwest Mississippi Development District—to carry out the planning. This is the first time such an approach has been used by a regional commission.

The purpose of the Region 11 study is to assess needs, develop a program of services to meet those needs, obtain a sound base of finances to support an ongoing program, and develop methods of involving the community with professional staff in implementation of community-based mental health services.



# Smallpox Vaccinations Are Not Necessary

Smallpox vaccinations are no longer recommended routinely say state health officials.

"However, the small but measurable risk of smallpox importation requires attention to a continuing control effort," noted Dr. Durward Blakey, director of the State Board of Health's Division of Preventable Disease Control.

Accordingly, public health efforts follow the recommendations of the Advisory Committee on Immunization Practices to assure routine immunization only for personnel involved in the medical services.

Dr. Blakey also stated the importance of vaccinations for all travelers to and from continents where smallpox has not been eradicated. Prospective travelers should make inquiry to their local health department concerning need for vaccination.

"But as a routine childhood immunization,

smallpox vaccine is no longer suggested," he emphasized.

## William F. Roberts Joins MSMA Staff

William F. Roberts has joined the MSMA staff as an executive assistant with primary duties in legislation and staffing the programs of the Council on Medical Service, according to Charles L. Mathews, MSMA Executive Secretary.

The 28-year-old Roberts is a native of Pascagoula and holds a B.A. degree from Ole Miss and a J.D. from the Jackson School of Law. He fills a MSMA position left vacant by promotion in June of 1972.

Roberts has held responsible administrative positions with the Mississippi Medicaid Commission and the Blue Cross and Blue Shield Plan of Mississippi, Inc. for the past three years while attending night school at the Jackson School of Law and receiving his J.D. Prior to that he served as a captain in the U. S. Army Tank Corps and commanded a tank platoon in Vietnam.

# Money Mileage

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M J

## State Charity Hospitals Seek Medical Directors

The Board of Trustees, Eleemosynary Institutions of the state of Mississippi, is seeking physicians interested in a fulltime position as medical director at one of the three hospitals: Natchez Charity Hospital, South Mississippi State, and Kuhn Memorial State Hospital.

The salary is open, according to James C. Stubbs, director. Interested applicants should write or contact the board's office, 1404 Woolfolk Building, Jackson 39201.

## Robins Establishes Family Planning Panel

An Advisory Panel for Family Planning and Birth Control, each member of which is a Diplomate of the American Board of Obstetrics and Gynecology, has been established by A. H. Robins Company, Richmond-based pharmaceutical manufacturer.

The company, which produces the Dalkon Shield®, an intrauterine contraceptive device, and Dalkon Foam™, a contraceptive foam, is sponsoring the panel as a free service to physicians active in family planning and birth control.

Panel members will be available to consult with any physician with an inquiry or problem related to intrauterine contraceptive devices or any other birth control method.

Physicians may request a consultation with a panelist through an A. H. Robins representative, or may personally initiate a consultation.

In addition to consulting with private physicians throughout the country, the panelists also will assist the A. H. Robins medical staff in responding to inquiries concerning the Dalkon Shield, Dalkon Foam and other related products which the company may add to its line, and provide consultation to A. H. Robins research personnel in developing new products and initiating clinical studies.

The new panel has five members located in Philadelphia, Detroit, Houston, Los Angeles and San Francisco. The company anticipates that the size of the panel will be increased in the future.

## 1974 MSMA-Robins Award Is Announced

The thirteenth annual Mississippi State Medical Association-Robins Award for outstanding community service by a state physician has been announced to the component medical societies by the Board of Trustees. The 1974 award will be presented at the 106th Annual Session during closing ceremonies on May 9.

Dr. A. A. Derrick, president, and Dr. James O. Gilmore, chairman of the Board of Trustees,

said that each component medical society had been invited to submit a nomination for the honor. The award is cosponsored annually by the association and the A. H. Robins Company of Richmond, Va., a long-established manufacturer of ethical pharmaceuticals.



*MSMA-Robins Award*

Drs. Derrick and Gilmore said that nominees must be

members of the state medical association and that the community service recognized by the local society's nomination must be apart from purely professional attainment, since suitable awards in this connection already exist.

Generally, the service by the physician-nominee should have benefitted the local or state communities in a civic, cultural, or general economic sense. It need not, however, have been a single achievement, since many outstanding citizens contribute to community betterment through a series of services in varying leadership roles.

Nominations should be made by letter, and there are no restrictions upon length or attached exhibits which assist in establishing the nominee's qualifications and record of achievement. Drs. Derrick and Gilmore said that each letter of nomination must be signed by an officer of the component medical society. Nominations from previous years may be resubmitted.

Deadline for submission of nominations to the state medical association is Jan. 1, 1974. Each nomination will be acknowledged, and the Board of Judges, consisting of the three MSMA vice presidents, will review the nominations.

The Robins series was instituted in 1962, and



the award consists of a sculptured bronze plaque in *bas* relief, engraved, and mounted on a mahogany panel.

The 12 Mississippi physicians who have received the high honor are Dr. Thomas G. Ross of Jackson, nominated by the Central Medical Society in 1962; Dr. Frank M. Davis of Corinth, by the Northeast Mississippi Medical Society in 1963; Dr. Howard A. Nelson of Greenwood, by the Delta Medical Society in 1964; and Dr. Maura J. Mitchell of Ellisville, by the South Mississippi Medical Society in 1965.

Dr. J. T. Davis of Corinth, by the Northeast Mississippi Medical Society in 1966; Dr. Frank M. Acree of Greenville, by Delta Medical in 1967; Dr. W. H. Anderson of Booneville, by Northeast in 1968; Dr. Omar Simmons of Newton, by the East Mississippi Medical Society in 1969; Dr. W. J. Aycock of Calhoun City, by the Northeast Society in 1970; Dr. Walter H. Rose of Indianola, by Delta Medical in 1971; Dr. Reginald P. White of Meridian, by the East Mississippi Medical Society in 1972; and Dr. W. A. Long, Jr., of Jackson, by the Central Medical Society in 1973.

## Marguerite Piazza Addresses Cancer Society

Famed singer Marguerite Piazza was special guest speaker at the American Cancer Society,



*Mrs. William Waller of Jackson, Mississippi's first lady and honorary chairwoman of the Uterine Task Force, presents gift to special guest, opera star Marguerite Piazza.*

Mississippi Division, Inc., general assembly held at Primos Northgate in Jackson in September.

Miss Piazza gave her personal story of her battle with melanoma and urged her audience to heed the seven warning signals of cancer. She concluded her address by singing "You'll Never Walk Alone."

Other highlights of the annual meeting included election of officers and formal beginning of the campaign against uterine cancer which has the theme, "Let No Woman Be Overlooked."



*Dr. Loren Breland of Crystal Springs, 1973-74 ACS state president, unveils promotional material for campaign against uterine cancer.*

Special Service awards were given to outstanding lay and medical ACS volunteers including Drs. Edward Lowicki of Jackson and W. C. Jones of Forest for service to professional education.

Dr. Loren Breland of Crystal Springs assumed the presidency of the Mississippi organization. Outgoing president was Dr. Frank A. Wood of Jackson.

Dr. Thomas Barnes of Greenville is first vice president and Dr. A. E. Brown of Columbus and Dr. Hardy Woodbridge of Jackson are area vice presidents.

Overall theme of the American Cancer Society in 1973 is "People to People," according to Richard E. Barba of Jackson, ACS Executive Vice President.



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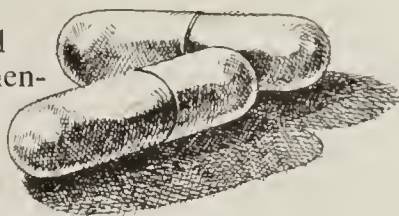




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### **Helps reduce anxiety-related G.I. symptoms**

A patient may blame his attacks of gastritis or duodenitis on "something he ate" but contributing factors may be his job, marital problems, financial worries or some other unmentioned source of stress and excessive anxiety that exacerbated the condition. Whether it is "something he ate" or "something eating him," adjunctive Librax can help. Librax offers both the antianxiety action of Librium® (chlordiazepoxide HCl), that can help relieve excessive anxiety, and the dependable anticholinergic action of Quarzan® (clidinium Br), that can help reduce gastrointestinal hypermotility and hypersecretion.



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**Before prescribing, please consult complete product information, a summary of which follows:**

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions

in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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## UMC Offers Lab Personnel Study Units

New instructional materials for laboratory personnel are now available on a loan basis from the University of Mississippi Medical Center.

Dr. Thomas E. Freeland, dean of the School of Health Related Professions, said the school has been named distribution center for the series of audiovisual study units. The units—slide/lecture tapes on various laboratory techniques—were produced by the National Committee for Careers in Medical Laboratory of the American Society of Clinical Pathologists and College of American Pathologists.

Subject areas of the study units include blood-banking, serology, urinalysis, coagulation and hematology.

"Each unit," Dr. Freeland pointed out, "has several presentations on the subject area. For example, the unit on bloodbanking includes eight lecture/slide presentations, ranging from 'basic review of blood' to 'complications of transfusion.'"

Dr. Freeland said there's no charge for use of the instructional materials except for postage fees. They may be obtained by writing him in the School of Health Related Professions at the University Medical Center, 2500 North State Street, Jackson 39216.

Units available for loan are:

### Volume I—*Bloodbanking, Serology, and Urinalysis*

#### Bloodbanking

##### Introduction

Lecture 1—Basic Review of Blood and Component

Lecture 2—Blood Collection

Lecture 3—Complications of Transfusion

Lecture 4—Pre-transfusion Testing

Lecture 5—Special Problems and Pre-transfusion Testing

Lecture 6—Hemolytic Disease of the New-born

Lecture 7—Blood Group Antibodies

Lecture 8—Quality Control and Administration

#### Serology Series

##### Introduction

Lecture 1—Serology—General Review

Lecture 2—Serodiagnosis of Syphilis

Lecture 3—Serodiagnosis other than Syphilis and Bloodbank—Part I

Lecture 4—Serodiagnosis other than Syphilis and Bloodbank—Part II

Lecture 5—Immunodiagnostic Test for the Detection of Autoimmune Mycotic, Parasitic and Venereal Diseases—Part I

Lecture 6—Immunodiagnostic Test for the Detection of Autoimmune Mycotic, Parasitic and Venereal Diseases—Part II

Lecture 7—Quality Control in the Serology Laboratory

#### Urinalysis Series

Lecture 1—Routine Chemical Tests

Lecture 2—Examination of the Urinary Sediment

Lecture 3—Special Chemical Tests

### Volume II—*Coagulation, Hematology*

#### Coagulation Series

##### Introduction

Lecture 1—Blood Coagulation

Lecture 2—Routine (Screening) Procedures

Lecture 3—Specific Tests for Individual Factors

Lecture 4—Fibrinolysis

#### Hematology Series

##### Introduction

Lecture 1—Fundamental Teachings in Hematology

Lecture 2—Quality Control in Hematology

Lecture 3—Abnormalities in Red Cell Morphology: Part I

Lecture 4—Abnormalities in Red Cell Morphology: Part II

Lecture 5—Abnormalities in Red Cell Morphology: Part III

Lecture 6—Normal Cells in Peripheral Blood

Lecture 7—Atypical and Abnormal Cells of the Peripheral Blood

Lecture 8—Cytochemistry in Diagnostic Hematology

Lecture 9—Laboratory Tests in the Diagnosis of Sickle Cell Disease: Part I

Lecture 10—Laboratory Tests in the Diagnosis of Sickle Cell Disease: Part II

Lecture 11—Laboratory Tests in the Diagnosis of Sickle Cell Disease: Part III

Lecture 12—Hemoglobin Electrophoresis

Lecture 13—Hematology Special Procedures: Part I

Lecture 14—Hematology Special Procedures: Part II



## Dr. Michael DeBakey Speaks at Tupelo

The really significant work to be done in the realm of heart disease lies in research to prevent various aspects of disease, particularly damage to the arteries, Dr. Michael DeBakey of Houston, Tex., told members of the Northeast Mississippi Medical Society at their September meeting at the Tupelo Country Club.

Dr. DeBakey showed slides of instances in which dacron arteries had been used to bypass clogged areas in arteries. He termed heart transplants "very inefficient and very costly," explaining that it is far more efficient to keep the arteries clear and healthy.

Though he saw little significance in heart transplants, Dr. DeBakey said that there is a need for artificial hearts to serve as a temporary aid to assist circulation. He also called for increased research funds on the prevention of heart diseases.

Dr. DeBakey is president and chairman of the department of surgery, Baylor College of Medicine, and director of Cardiovascular Research and Training Center, Methodist Hospital, Houston. Also a medical instrument inventor, Dr. DeBakey has authored more than 850 publications.

Among his consultative appointments are Consultant in Surgery, Walter Reed Hospital, and Surgical Consultant to the Surgeon General, United States Army.

Dr. DeBakey is a graduate of the Tulane Medical School and completed residency and postgraduate training at Charity Hospital in New Orleans and the University of Strasbourg and Heidelberg, Germany.

## Eaton Loans Cassettes to Urology Departments

In keeping with the latest educational methods, Eaton Laboratories will provide color videocassette players and T.V. receivers to urology departments in 100 medical teaching institutions throughout the United States, according to Frank M. Ault, vice president and general manager of Eaton. The University of Mississippi School of Medicine at Jackson is included.

The videocassettes will be loaned on a long-term basis to each urology department as part of Eaton's program designed to help enrich the con-

tent of undergraduate and postgraduate medical education.

Eaton's medical representatives presented the videocassette systems to the chief of the urology department in each institution during the week of Sept. 24, 1973. At the same time, each department was given several videocassettes containing 22 films from Eaton's Library of Surgical and Medical Science Teaching Films. In the future, Eaton will provide additional videocassettes at intervals to help build up each institution's own library.

The Eaton library has available more than 150 films on urology, plastic and reconstructive surgery, burn therapy, gynecology, dentistry, neurology, and cardiovascular surgery. Four of these 16 mm. sound color films have won "Golden Eagle" awards for excellence from the Council on International Nontheatrical Events (CINE). Available on a free loan basis, films from the library are seen, on the average, by more than 9,000 different groups each year—students, physicians, nurses and other medical personnel—with a total audience of nearly 90,000 persons.

The videocassette player makes it possible to view videotape prints on an ordinary color television receiver. As in other educational settings, the system can be used whenever it is convenient for staff members, residents, interns and medical students who wish to study special programs.

## Venereal Disease Increases in Mississippi

"Reported venereal disease cases continued to rise in Mississippi during fiscal year 1973," states Dr. Durward Blakey, director of Preventable Disease Control, Mississippi State Board of Health. Gonorrhea, which is presently of epidemic proportions throughout the nation, increased in the state by more than 3,700 cases over last fiscal year with a total of 14,060 cases reported. Syphilis, which usually occurs in outbreaks, decreased slightly with 634 early cases reported; 7 fewer than last year.

In an effort to reduce gonorrhea to a controllable level, the State Board of Health supplied materials to health services throughout the state for routine testing of asymptomatic females. Of the 97,748 tests performed, 6,293 gonorrhea infections were identified. The large majority of persons found to be infected were not aware that they had gonorrhea.

## Dr. Arthur Guyton Receives ACCP Award

Dr. Arthur C. Guyton, chairman and professor, department of physiology and biophysics, University of Mississippi Medical Center, Jackson, has been named 1973 winner of the Distinguished Lectureship in Physiology Citation of the American College of Chest Physicians. The citation is one of the four highest honors given by the ACCP.

Dr. Guyton was honored at the convocation of the ACCP's 39th Annual Scientific Assembly, October 22-25, 1973, in Toronto, Ontario, Canada. Approximately 200 physicians were inducted as Fellows of the college at the same convocation.

Dr. Guyton, 54, a native of Oxford, is a member of the publications board of the American Heart Association and of the council of the American Physiological Society.

## Nurses Get Training In Care of Burns

HEW's Division of Nursing, through a \$306,514 contract with the University of Texas, is supporting the first educational program specifically tailored to prepare nurses for expanded roles in the care of burn patients.

The division is a component of the Bureau of Health Resources Development in HEW's Health Resources Administration.

Under the three-year contract, the University of Texas Southwestern Medical School at Dallas, in collaboration with the Texas Woman's University, is developing a two-year master's level program to produce teachers and beginning researchers as well as specialized nurse practitioners in the burn field. Students may apply credit for this program, and also for a third, optional year of study focusing on clinical, biomedical, or psychosocial research toward a doctorate in nursing from Texas Woman's University.

The new graduate nursing program has significance for staffing centers now being established throughout the country to cope with burns, which are a major cause of injury and death, and the leading cause of death among children between ages one and eleven. It is also expected to result in a model curriculum to help other universities offer practitioner study in this nursing area.

## Radiologic Tumor Diagnosis Course Set

The eighteenth annual clinical conference will be held Nov. 8 and 9, 1973, at Texas Medical Center in Houston. Theme of this year's course is radiologic and other biophysical methods in tumor diagnosis.

The conference is sponsored by The University of Texas System Cancer Center, M. D. Anderson Hospital and Tumor Institute and will be co-sponsored by The University of Texas Health Science Center at Houston and the American Cancer Society.

There is no tuition fee and the course will be given at the Shamrock Hilton Hotel.

The program is acceptable for 13 hours prescribed credit by the American Academy of Family Physicians.

For further information write Clinical Conference Registration, The University of Texas M. D. Anderson Hospital and Tumor Institute at Houston, Houston, Tex. 77025.

## Dermatologists Meet in Chicago

The 32nd Annual Meeting of the American Academy of Dermatology will be held Dec. 1-6, 1973, at the Palmer House in Chicago. More than 2,600 skin disease specialists and research scientists are expected to attend the six-day meeting.

Dr. John R. Haserick, Pinehurst, N. C., president of the 4,000-member medical specialty society, announced that the 1973 meeting will have the most varied scientific program ever presented by the American Academy of Dermatology—with some 490 physicians and investigators serving as speakers, members of the faculty and scientific exhibitors.

The sessions will include some 128 breakfast and luncheon discussions, 49 seminars-in-depth, 23 symposia, nine special courses, a half-day resident's forum and two special lectures.

Among other events will be special sessions on peer review and audiovisual aids and the premiere showing of a new motion picture for the general public, "Outer Limit—the Amazing Story of the Skin."

Also scheduled are the presentation of 21 scientific and some 140 technical exhibits, plus a three-day special exhibit on learning resources.



## Drugs and Sports Don't Mix

The use of drugs as an aid to athletic performance has been condemned by the American Academy of Pediatrics' Joint Committee on Physical Fitness, Recreation, and Sports Medicine in the September issue of *Pediatrics*.

Noting that some athletes and coaches have tried nutritional, physical, and pharmacological methods of increasing performance, the committee said "there is no scientific basis for any such practices."

The statement dealt in particular with two types of drugs—anabolic steroids, used mainly for weight gain, and amphetamines.

The committee said several side effects have been associated with the use of steroids, including precocious sexual development in boys and the possibility of masculinization in girls.

Research in the use of steroids has not demonstrated increases in strength, the committee said. "Athletes who claim gain in weight and increased athletic performance appear to have taken self-administered doses of steroids far beyond the therapeutically recommended amount of these drugs," the committee said. "The results are questionable at any age, and highly undesirable in adolescence."

On amphetamines, the committee said the drugs may improve physical performance if the athlete is fatigued, but the individual's judgment, and his estimate of his own performance, may be impaired.

"The amphetamines are dangerous because of their hazardous effect of masking the signs of fatigue or exhaustion," the statement said. "Thus, the drug may be harmful to the stressed athlete." More harmful side effects—including psychological dependence—may occur with chronic use, the committee noted.

The committee also warned against the frequent use of "downers"—mainly barbiturates—to help athletes obtain restful sleep before a performance. Their frequent use is hazardous because of "detrimental effects on performance and the possibility of psychological dependence," the committee said.

The committee also said there is no scientific evidence to indicate that special foods, vitamins, massages, ultraviolet lights, breathing oxygen, or nutritional supplements can improve the ability of an already healthy athlete.

"Young people today grow up with the notion that there is a drug to hasten recovery from practically every illness and that a healthy person can be even better off if he has something special in his diet or in his manner of living," the committee said.

"The result of these beliefs and attitudes is a host of misconceptions about ways by which a healthy individual can be improved by a miracle drug, a special diet, a vitamin, a hormone, particular exercises, or some other procedure."

The statement concluded: "No drug can safely make the athlete better than he would normally be. The facts and dangers regarding the use of anabolic steroids, stimulants, and sedatives should be made available to athletes, coaches, parents of young athletes, and physicians.

"All of them should know that the misguided use of ergogenic aids to improve athletic performance is contrary to good medical care, harmful to physical and mental health, and counter to ethical and sportsmanlike participation in athletics."

## 1974 Medical Hypnosis Workshops Set

Introductory and advanced workshops in medical hypnosis will be held in conjunction with the 26th Annual Scientific Meeting of the Society for Clinical and Experimental Hypnosis at the Ritz-Carlton Hotel, in Montreal, Oct. 8-11, 1974. The workshops will be followed by the scientific program which concludes on the afternoon of Oct. 13.

The workshops are under the sponsorship of the Departments of Psychiatry at Université de Montréal and McGill University, the Departments of Psychology at Sir George Williams University and Université de Montréal, the Institut national de la recherche scientifique, secteur santé, and Hôpital Saint-Jean-de-Dieu.

These meetings will celebrate the 25th anniversary of the society, and will mark the first time that the convention has been held outside of the USA.

For further information, write to: Germain Lavoie, Ph.D., Workshops' Chairman—SCEH 1974, Hôpital Saint-Jean-de-Dieu, Montréal-Gamelin, Québec, Canada.

## Dr. R. Clark Appointed to Planning Council

Dr. Richard H. Clark of Hattiesburg has been appointed chairman of the State Health Planning Advisory Council. The appointment was announced by Governor Bill Waller.

The council serves in an advisory capacity to the Division of Comprehensive Health Planning, office of the governor.

Dr. F. Lindsey Risher, executive director of the Division of CHP, said that Dr. Clark will serve a four year term.

Dr. Clark, a surgeon with the Hattiesburg Clinic, P.A., since 1961, is a graduate of Tulane University School of Medicine and completed his residency in surgery at Charity Hospital of Louisiana at New Orleans. He is a fellow of the American College of Surgeons, American College of Chest Physicians, and a diplomate of the American Board of Surgery.

He is a member of the Alton Ochsner Surgical Society, AMA, MSMA and is president of the board of directors, Southeast Mississippi Air Ambulance District, based in Hattiesburg.

The new advisory council chairman is also chairman of the Mississippi Trauma Committee of the ACS, chief of staff at Forrest General Hospital, and Health and Safety chairman, Hub District Boy Scouts of America.

The State Health Planning Advisory Council is charged with the responsibility for identifying health care needs and problems in Mississippi and for studying methods of implementing recommended improvements. The advisory council is the sole state agency responsible for the review of capital expenditures by health facilities receiving federal money under the Social Security Act.

As chairman of the Advisory Council, replacing Meridian attorney William E. Ready, Dr. Clark will coordinate the council's activities, preside over quarterly meetings and appoint committees and task forces which he considers necessary to deal with special areas of concern to health care.

## ACS Surveys Hospital Cancer Programs

The American College of Surgeons' Commission on Cancer is surveying hospital cancer pro-

grams across the country in order to establish categories of types of care rendered by hospitals which qualify for approval of their cancer programs.

These categories will not relate to quality of care, but rather to the types of care the hospitals can render, ranging from limited treatment to treatment of malignancies in any part of the body.

Dr. Andrew Mayer, assistant director of professional activities in charge of the college's cancer program, explains in the September *Bulletin* that "members of the Commission on Cancer recognized only one acceptable level of care for cancer patients."

That is "that of the highest quality presently known to the medical profession."

Dr. Mayer said the commission recognizes that "small hospitals may have the facilities and personnel to deliver this highest of quality of care to patients with cancer of some anatomical sites, while referring patients with cancer of other anatomical sites to hospitals that are more adequately prepared to give this high quality of care."

To establish these categories a questionnaire was mailed to the institutions presently conducting an approved cancer program. Based on results of this mail survey, institutions will be assigned a category and the college will then publish the annual list of approved hospital cancer programs by category.

Dr. Mayer pointed out that approval of a hospital cancer program relates only to established criteria of organization, personnel and facilities and that it does not directly relate to patient care evaluation.

With the new criteria, the commission has added a requirement that in order to be approved hospitals must have an established system for patient care evaluation, with documentation of its operation.

The commission used only a small number of major differences in developing its plan of categorization. While the commission recognizes the existence "of a myriad of other existing variables of major and minor importance," it felt that "the widespread interlocking of these variables would make their use in categorization highly impractical."

Regardless of category, all hospitals with approved cancer programs must be accredited by the Joint Commission on Accreditation of Hospitals. They must also have a multidisciplinary cancer committee responsible for maintaining a cancer registry with periodic reports to the hos-



pital staff, for multidisciplinary cancer conferences, for consultation services and for the evaluation of quality of patient care.

Three regular categories and one special category of care have been established. These categories are based on sophistication and amount of cancer treatment provided by the institution, the number of patients treated each year, residency training programs, and research programs.

The American College of Surgeons has long been involved in promoting high quality of care for cancer patients. Its first committee involved in such a program was established in 1931, and in 1933 it published its first list of institutions with approved cancer programs.

In 1956 the college inaugurated a major change in criteria for approval in requiring that approved hospitals must maintain a cancer registry so that cancer patients could be followed throughout their lives and the results of their treatment could be evaluated.

Surveys are carried out on a continual basis. As of January 1973, the Approvals Program numbered 808 institutions. The list is published yearly in the April issue of the college's *Bulletin*.

## Belhaven Schedules 40th Singing Christmas Tree

One of the South's Christmas traditions will celebrate its 40th birthday on Nov. 30 and Dec. 1 when the famed Belhaven College Singing Christmas Tree heralds the yuletide season for thousands of Mississippians.

Begun in 1933 by the late Mrs. John T. Caldwell—former Belhaven voice professor—the tradition has grown over the years into Mississippi's major non-commercial tribute to the Christmas season.

Popular and traditional carols will flow from the boughs of the 145-voice tree for two consecutive nights at 8:15 p.m. in the college bowl where the 27 foot tree stands on a permanent concrete stage constructed last year as the beginning of an amphitheater at the college.

The thousands of Mississippians who attend the concert yearly are accustomed to bringing cushions and blankets and sitting on the ground (often frozen) to hear the hymns, anthems and seasonal music. Residents of the Belhaven area often listen to the music and enjoy the lighted tree from their own lawns.

Lighting for the tree is changed to match the mood or feeling of each song. Each singer holds five strands of lights (almost 800 lights are used) and they are controlled from a central panel. Flood or spot lights are also used to correspond with the color of lights on the tree.

The director, organist and technical director work from a large rectangular pit dug in the center of the bowl a few yards from the tree so that they are not seen and the effect is one of dignity and simplicity.

Costumes for the singers are white robes with sequin collars which reflect the colored lights.

The Singing Tree began in 1933 when the late Mrs. Caldwell invited the faculty and student body (Belhaven was then a girls' school) to a program of carols after the college's traditional Christmas dinner.

After this informal program for three years, Mrs. Caldwell and the college engineer realized that the residents of the area were anxious to attend the program. They designed and built the first wood pyramidal frame for the tree. This original design is thought to be the oldest of its type and has been mailed to schools and cities throughout the nation upon request.

Mrs. Caldwell directed the program until her retirement. When Henry Thomas Ford joined the Belhaven faculty in 1962, several changes were made. Belhaven had been coeducational for about eight years, so he thought it logical to add men singers to the tree. That year, a capacity crowd made it obvious that the setting would have to be moved from its traditional spot between the two Gothic columns overlooking the lagoon. So in 1963 a larger and taller tree was placed on the college bowl allowing seating space on three sides. So successful was the 1963 performance that business and civic leaders requested that the program be presented for three nights in 1964.

It was fitting in 1972 that John T. Caldwell, Jr., retired Jackson businessman and the son of the tree's founder became chairman of a committee to secure funds for a permanent amphitheater at Belhaven. Through the generosity of business and industry, a gigantic concrete stage was built in the college bowl, appropriate electrical work was completed and the new pit was constructed. Additional work will be done before the Nov. 30 performance.

The Singing Tree is a family tradition for many Mississippians. Yearly second and third generation singers are added to the tree.

# ACR Establishes Bone Tumor Referral Centers

Three bone tumor referral centers have been set up under the auspices of the American College of Radiology to offer diagnostic services to all interested physicians.

The centers, established at the recommendation of the ACR Commission on Cancer, and the radiologists in charge are: (1) Dr. John L. Gwinn, Children's Hospital, 4650 Sunset Boulevard, Los Angeles, Calif. 90054; (2) Dr. Gwilym S. Lodwick, University of Missouri School of Medicine, Department of Radiology, Columbia, Mo. 65201; (3) Dr. Jack Edeiken, Jefferson Hospital, Department of Radiology, 11th and Walnut Streets, Philadelphia, Pa. 19107.

Physicians at these three sites report receiving many cases since the centers were opened two years ago but are eager to accept new and more cases and serve physicians with special diagnostic problems. Physicians are advised to send their x-ray films, along with a history of the patient, and, whenever possible, histologic slides. All information should be sent directly to the physician in charge of the center.

Dr. Edeiken noted that "since the inception of this program I have been sent approximately three cases a week from various hospitals in the northeastern United States. In the past six months we have seen 80 cases."

He added that the cases are sent for review and are usually current problems. He said "The roentgenograms are reviewed and the physician is called immediately as to the advice of the films alone." He explained that all information is reviewed by himself, and if histologic slides are included a bone pathologist is called in for consultation.

Dr. Gwinn noted that he and his staff quickly review any bone tumor cases and try to phone the physician within 24 hours after receiving the request for a diagnosis. He, like the physicians at the other centers, reviews the cases with a comprehensive staff that includes a pathologist.

In July, 1971, Dr. Lodwick announced the opening of the Mid-American Bone Diagnostic Center and Registry in Columbia, Mo. Dr. Lodwick said that numerous referrals are received.

"We receive as many as seven or eight in some weeks," Dr. Lodwick said. "The value of the service is reflected in the fact that once we receive a referral, we are likely to receive numerous referrals from the same radiologist's crew. Our feed-

back has been almost invariably favorable. We believe that our advice as to whether or not to biopsy, and the future treatment, is probably as valuable as our opinion about the x-ray and our rapid telephone response on referred cases is very impressive to referring physicians."

He said that insofar as the registry is concerned, "We are rapidly increasing the size of our data base, which is most helpful in improving our diagnostic confidence. Stimulated by the available new material, we are now beginning to update our computer program for diagnosis, expanding them into other areas such as medistatic disease, dysplasias of bone, and the inflammatory disease of bone. This program has support of a grant from the National Cancer Institute."

While all three centers have excellent staffs and facilities for rapid handling of referral, and all three are eager to receive more cases, only Dr. Lodwick has set up the registry.

He explained that the staff's seven-step diagnostic approach remains the same as it was when the center opened:

- (1) Review of patient history and radiographs by Drs. Lodwick and Corine Farrell.
- (2) Computer analysis of radiographs.
- (3) Review of histologic sections.
- (4) Consultation by Drs. Lodwick, Farrell and Curtis Bourgeois, Jr., a consulting pathologist.
- (5) Relaying diagnosis to physician by telephone, followed by letter. Diagnostic evaluation includes an estimation of rate of growth, kind of disease or process, and a differential diagnosis. Where possible, proposed method of treatment is offered. Reports are made within the same day films are received.
- (6) Duplication of radiographs for accession to the registry and return of the originals to the physician.
- (7) Yearly follow-up maintained on each case.

The West Coast and East Coast centers follow a somewhat similar procedure for handling the diagnosis of all cases referred.

Dr. Lodwick noted that "The teaching implications of the program are not inconsiderable. New material is presented to the residents and staff of the department, and in conference with the orthopedic surgeons, maximum application is made of materials for the purpose of better patient care.

"Dr. Farrell, curator of the registry, has established an annual lectureship held in May. Two such lectures have been given. In addition, the



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Volume XIV

Number 12

December 1973



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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, \$7.50 per annum; \$1 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri.

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Booneville, Miss.

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## Hair Transplant Symposium Slated

The American Society for Dermatologic Surgery and The American Academy of Facial Plastic and Reconstructive Surgery, Inc., are co-sponsoring a conference which is designed to offer an opportunity for the exchange of ideas among various disciplines and to present the latest advances in techniques on hair transplantation.

The conference will be held Feb. 8 and 9, 1974 at the Stough Dermatology and Cutaneous Surgery Clinic, P. A., Doctors Park, Hot Springs, Ark. 71901. Attendance will be limited.

Faculty will include dermatologists, otolaryngologists and general plastic surgeons.

For further information, contact: Dr. D. B. Stough, III, Program Director.

## Medical Schools Set Record Enrollments

The most medical schools since 1925—114—opened their doors for the 1973-74 school year in the United States, says a report in an October issue of *American Medical News*, a publication of the American Medical Association.

The first-year entering class hit an estimated 13,790—also a new record—and total enrollment for the first time topped the 50,000 mark, with educators setting an estimate of 51,123, states the report, based on statistics compiled by the AMA's Medical Education Division.

If all senior students get a degree on schedule, there will be 11,862 new physicians at the end of the school year, the first time this figure has gone over the 11,000 mark.

First year enrollment last year was 13,726, with 47,546 the total enrollment for all classes. There were 10,391 graduates, the first time the number receiving M.D. degrees had topped the 10,000 mark in any one year.

There were 924 women in the 1973 graduating class and 6,099 women enrolled in all medical schools.

A continuous climb in the production of new physicians is likely. It is estimated that in 1974-75 first-year enrollments will rise to 14,336 and the number of graduates will exceed 13,000. The

first-year enrollment figure will reach 15,000 for the first time with the opening of the 1976 year.

The two new schools which opened for the 1973-74 school year are Southern Illinois University School of Medicine in Springfield and the Eastern Virginia Medical School in Norfolk.

## Invitation to Scientific Exhibitors



106TH ANNUAL SESSION

MAY 6-9, 1974

SHERATON-BILOXI

Prospective scientific exhibitors are invited to submit applications to MSMA, Box 5207, Jackson, Miss. 39216. Exhibitors are asked to give title of exhibit and author(s). Exhibits by individuals are encouraged and will be given equal consideration with exhibits by groups or institutions.

The Aesculapius Award will be presented to the association member or members having the best scientific exhibit.





ORIGINAL PAPERS

## Diabetic Retinopathy

DONALD L. HALL, M.D.

Shreveport, Louisiana

DIABETES MELLITUS is the second leading cause of new adult blindness; 84 per cent of the blindness in diabetes is secondary to the retinopathy.<sup>1</sup> Diabetes is the most common cause of new blindness in ages 41-60 years and the second most frequent cause of blindness in ages 21-40 years.<sup>2</sup> Because of the 9 per cent annual increase in the number of diabetics in the general population, it is predicted that there will be 573,000 blind diabetics in the U. S. in the year 2000. In 1970, there were only 500,000 blind individuals in the U. S. from all causes.<sup>3</sup>

The etiology of diabetic retinopathy is unknown, but it is known that hyperglycemia without insulin leads to saccharide formation which can combine with mucoid material to form mucopolysaccharides which are deposited in the basement membranes throughout the organs of diabetics. When mucopolysaccharides are deposited in the retinal capillaries, there is loss of the mural cells (pericytes) and microaneurysms develop at these sites. The microaneurysms alter the permeability of the capillaries, and retinal edema and exudation can occur. Shunt vessels develop. Vaso-obstruction, ischemia, and neovascularization ensue. This process is aggravated by hypertension.

The treatment of diabetic retinopathy falls into three categories: medical control, photocoagulation, and hypophysectomy. Some feel that the retinopathy in juvenile diabetes can be prevented by meticulous medical control and recommend crystalline insulin combined with smaller amounts of longer acting insulin in multiple daily injections with frequent meals. It is known that if one

is less than 20 years of age at onset of diabetes, the average length of time to onset of severe blindness is 17.4 years;<sup>4</sup> and duration appears to be the most significant factor related to the retinal vascular complications of diabetes.

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*The retinopathy of diabetes mellitus is a significant and increasing cause of blindness. The etiology of the retinopathy is unknown, but duration of the diabetic state appears to be the most significant factor related to onset of the retinal changes. Results of photocoagulation in a series of patients with maculopathy and in a series of patients with neovascularization are presented, and the traction retinal detachment of diabetes is discussed. Recommendations to primary care physicians are made.*

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Photocoagulation in diabetic retinopathy is accomplished with two instruments. The monocular xenon arc apparatus emits white light which is absorbed by melanin in the posterior retinal layer where it is converted to heat and the overlying vascular defects are coagulated by this thermal reaction. The binocular argon laser emits a blue-green light which can be absorbed by both melanin and hemoglobin. It has the real advantage of stereopsis for the surgeon and the theoretical advantage of closing vascular abnormalities elevated from the plane of the retina.

Ocular conditions which threaten vision and appear to call for treatment are macula edema and exudation, neovascularization (proliferative retinopathy), and traction retinal detachment.

---

Presented before the Section on EENT, Mississippi State Medical Association, Biloxi, May 3, 1973.

The first ophthalmoscopic sign of diabetes is the appearance of hemorrhages and microaneurysms temporal to the macula. The microaneurysms can leak blood products into the surrounding retina which can lead to macular edema and exudates which cause decreased central visual acuity. Neovascularization may play a part in the process but is less common in the diabetes of adult onset. Table I shows the results obtained by photocoagulation in a series of 27 eyes in 18 patients of at least 50 years of age with maturity onset diabetes. All patients had decreased vision secondary to maculopathy and there was an average follow-up of 19 months (3 months-6 years, 10 months). Table II compares the final visual acuity to pretreatment levels. Results in this series of patients suggest that faster clearing of maculopathy with better visual results is obtained when photocoagulation is done before vision falls to 20/200 or worse. Presumably, chronic retinal changes occur which lead to decreased ability of the macula to clear itself of edema and exudate.

#### NEOVASCULARIZATION

The new retinal vessels formed in diabetes are abnormally permeable and fragile. They leak blood products into the retina and vitreous cavity and bleed readily. The most common sites for neovascularization are the temporal vascular arcades, optic disc and the retinal equatorial region. It has been stated that 50-60 per cent of eyes with early proliferative (neovascularization) retinopathy are blind within five years.<sup>5</sup> It is known that one-third of the eyes which have experienced an intraocular hemorrhage are blind in one year and another one-third have permanently impaired vision.<sup>5</sup> In a series of 335 eyes in 210 patients followed up to seven years, in whom the author participated in the photocoagulation for retinal neovascularization, 54 per cent stabilized visually. In 11 per cent the progress was slowed (vision decreased no more than two lines) and 35 per cent progressively lost vision (see Table III). In a series of 59 control eyes which were followed by Taylor and Dobree for three years, 62 per cent worsened.<sup>6</sup> Taylor further states that if one is treating an eye after the fellow eye is blind, 26 per cent of these patients are bilaterally blind over a follow-up of six months to six years.<sup>6</sup> Patz has shown that 59 per cent of second eyes are blind in 12 months if untreated.<sup>7</sup> From this data it can be concluded that photocoagulation is helpful in preserving vision in proliferative disease.

TABLE I

MACULOPATHY		
Stabilized	Progression Slowed	Progressed
82%	7%	11%

Neovascularization from the optic disc poses a special problem. It is not possible to treat on the optic disc with the xenon arc photocoagulator without damage resulting in the optic nerve manifested by visual field defects and loss of visual acuity. It is possible to treat neovascularization from the optic disc with the argon laser. Because 50 per cent of eyes with disc neovascularization are blind in three years,<sup>8</sup> it is hopeful that the argon laser will prove beneficial in this problem. Due to the special problem encountered with disc neovascularization, there has been a resurgence of interest in the Aiello treatment or peripheral retinal ablation. It is known that the retinopathy of diabetes is less manifest in patients with optic atrophy, retinitis pigmentosa, high myopia, glaucoma, disseminated chorioretinitis and carotid artery stenosis. The reason for the decreased neovascularization in these conditions is probably the reduced nutritional requirements of the retina in these entities. Aiello has shown that ablation of the retinal periphery by photocoagulation can cause a reduction in proliferative retinopathy.<sup>9</sup> This treatment approach is now being employed by many for the unique problem of neovascularization arising from the optic disc.

TABLE II

MACULOPATHY			
27 Eyes in 18 Patients			
	FINAL OBSERVATION		
	Good Vision	Impaired Vision	Blindness
Initial Good Vision (20/20-20/50)	66%	17%	17%
Initial Impaired Vision (20/60-20/100)	57%	29%	14%
Initial Blindness (20/200 or less)	0%	21%	79%

Poulsen in 1953 observed a patient with background diabetic retinopathy who had a postpartal pituitary hemorrhage with Simmonds' disease resulting and in whom the retinopathy improved.<sup>10</sup>



This event stimulated pituitary ablation for treatment of diabetic retinopathy. It has been postulated that pituitary ablation has a beneficial effect on diabetic retinopathy through decreased growth hormone production. At present, pituitary ablation is recommended for those patients who have very extensive proliferative disease (rubeosis retinae) where photocoagulation to all the disease present would destroy most retinal function.

TABLE III

PROLIFERATIVE DISEASE		
Stabilized	Progression Slowed	Progressed
54%	11%	35%

Diabetic retinal detachments are usually of the traction type secondary to preretinal fibrosis, which occurs in response to the neovascularization, and to vitreous traction. These detachments are often central and remain stationary for long periods and surgery is recommended only if the macula is detached or threatened. Reattachment is accomplished by an operation which includes an encircling element about the eye to support the areas of traction. The anatomical reattachment rate is much less in this type of retinal detachment than in rhegmatogenous retinal detachments. Reattachment and maintenance of useful visual acuity were accomplished in 60 per cent of a series of 50 eyes in 41 patients in which the author participated in the surgery. This compares favorably to the results obtained by Okun.<sup>11</sup>

SUMMARY

Although the final solution to diabetic retinopathy has not been found, photocoagulation is beneficial in the preservation of vision in this condition. It is recommended that the primary care physicians (family practitioners, pediatricians, and internists) obtain an ophthalmologic evaluation on all juvenile diabetics within five years of

the diagnosis and on all adult diabetics with any visible retinopathy. These patients should be followed indefinitely so that early treatment may be instituted at the first signs of neovascularization or macular decompensation. ★★★

2751 Virginia Avenue (71103)

ACKNOWLEDGEMENT: The series of patients cited in this paper was compiled by the author while serving a Heed fellowship with Gilbert W. Cleasby. The maculopathy series was presented by the author at the Conference on Photocoagulation Treatment for Diabetic Retinopathy, at Vail, Colorado, 1972.

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# Opinions of Mississippi Pediatricians, Obstetricians and Gynecologists Relative to PKU Screening and Diet

KENNETH C. STEINER, M.S.,  
University, Mississippi, and  
HARRY A. SMITH, Ph.D.  
Lexington, Kentucky

PHENYLKETONURIA (PKU) is only one of several forms of mental retardation; however, mental retardation is one of the major health problems in the United States today. The number of mentally retarded patients of any given population ranges from one per cent to three per cent.<sup>1</sup> The causes of mental retardation are varied. They include not only organic brain damage but also metabolic disorders. PKU is one example of a metabolic disorder. It results from a rare, but well-described inborn error of metabolism usually associated with mental retardation. This hereditary disease is somewhat unique in the area of mental deficiency. It is readily detected, and when diagnosed early in life, the deficiency can be modified or prevented with dietary treatment,<sup>2-5</sup> although some authorities have questioned this treatment.<sup>6-9</sup>

A Norwegian physician and biochemist, Dr. Ashborn Fölling, was the first to describe this metabolic disorder in 1934.<sup>10</sup> As early as the 1950s, the incidence rate was estimated as 1 in 40,000,<sup>11</sup> but recent studies and new detection methods have shown a higher incidence rate of 1 in 10,000<sup>12</sup> to 1 in 15,000.<sup>13</sup>

As of April 1968, 43 states had laws pertaining to PKU.<sup>14</sup> The person responsible for administering the screening test and initiating the diet in PKU programs is the physician.<sup>14</sup> The legislation making these programs mandatory has been widely criticized.<sup>15</sup> In fact, several physicians have been defendants in malpractice suits, where there was a mandatory program, for failing to diagnose PKU and initiate treatment.<sup>16</sup>

It was decided that a survey of the attitudes of selected Mississippi physicians to PKU screening programs would be valuable, since many physi-

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*Phenylketonuria is a metabolic disorder causing mental retardation but which can be modified by dietary treatment if detected early in life. Forty-three states now have mandatory PKU screening and treatment programs. This paper is the report of a survey of selected state physicians to learn their attitudes toward PKU screening programs.*

---

cians would be directly involved if a state screening program were initiated. After some assessment of the number of physicians in the state and communication with the Executive Secretary of the Mississippi State Medical Association, it was agreed that only the pediatricians, obstetricians and gynecologists would be surveyed because these physicians would be most knowledgeable concerning PKU. A brief questionnaire was developed to gather the opinions from these physicians on certain aspects of PKU along with a cover letter which explained the purpose of the study and requested their cooperation.

Questionnaires were sent to 86 pediatricians and 100 obstetricians and gynecologists in Mississippi. Of the 186 questionnaires that were mailed, 95 (51.1 per cent) were returned. This includes 56 (65.1 per cent) from pediatricians and 39 (39 per cent) from obstetricians and gynecologists. The questions dealt with opinions and activities relative to PKU detection. The physicians were asked how frequently they tested

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From the Department of Health Care Administration, University of Mississippi School of Pharmacy, and the University of Kentucky College of Pharmacy.



newborn infants for PKU. Their responses are summarized in Table I.

TABLE I  
PHYSICIAN ACTIVITY IN SCREENING OF  
NEWBORNS FOR PKU

	<i>Pediatrics</i>		<i>Obstetrics-Gynecology</i>	
	NO.	PER CENT	NO.	PER CENT
Every newborn	35	53.0	19	44.2
Every newborn in the hospital	9	13.6	7	16.3
Most newborns in the hospital	8	12.1	1	2.3
Some newborns in the hospital	7	10.6	2	4.7
Never	4	6.1	5	11.6
Did not answer question	3	4.6	9	20.9
Total	66*	100.0	43*	100.0

\* These totals should add to 56 and 39, respectively. Differences are due to some physicians' indicating more than one choice in answering the question.

It was apparent that pediatricians seemed to be more aware of the prevalence and danger of PKU; however, over 60 per cent of both groups either tested every newborn infant or all the newborns delivered in the hospital.

The physicians were asked their opinions concerning the effectiveness of PKU screening programs and the low phenylalanine diet programs. The results are reported in Tables II and III.

The physicians who answered the questionnaire, especially the pediatricians, showed a general positive attitude toward a phenylketonuria detection program. This is shown by the 41 (73 per cent) responding pediatricians who considered a detection program to be effective. Also, 33 (58.9 per cent) of the responding pediatricians considered the low phenylalanine diet to be effective to some degree. Again, it was obvious that pediatricians were more concerned about PKU since only 16 per cent failed to answer the question on the effectiveness of PKU screening programs and 39 per cent failed to answer the question of the effectiveness of the special diet. These findings no doubt reflect the more frequent contact pediatricians have with mentally retarded children, PKU victims included.

The obstetricians and gynecologists did not respond to the questionnaire as anticipated. Thirty-nine questionnaires were returned out of the 100 sent. The reasons for not answering the questions were deduced from the comments of the respondents regarding certain questions. Their primary

reasons were they did obstetric work only or they had no opinion on the subject. As with the pediatricians, the obstetricians and gynecologists

TABLE II  
PHYSICIANS' OPINIONS OF A PKU  
DETECTION PROGRAM

	<i>Pediatrics</i>		<i>Obstetrics-Gynecology</i>	
	NO.	PER CENT	NO.	PER CENT
Very effective	21	37.5	9	23.1
Fairly effective	20	35.7	8	20.5
Ineffective	6	10.7	1	2.6
Did not answer question	9	16.1	21	53.8
Total	56	100.0	39	100.0

TABLE III  
PHYSICIANS' OPINIONS OF A LOW  
PHENYLALANINE DIET

	<i>Pediatrics</i>		<i>Obstetrics-Gynecology</i>	
	NO.	PER CENT	NO.	PER CENT
25 per cent effective	4	7.1	0	0.0
25-50 per cent effective	8	14.3	1	2.6
50-75 per cent effective	11	19.6	4	10.2
75-100 per cent effective	10	17.9	1	2.6
Ineffective	1	1.8	0	0.0
Did not answer question	22	39.3	33	84.6
Total	56	100.0	39	100.0

stated a lack of experience or they had not seen a PKU patient as other reasons. Eight (21 per cent) of these physicians stated they referred their newborns to pediatricians as a reason for not answering the questions.

The obstetricians and gynecologists were not as favorable as the pediatricians with regard to a PKU detection program. Seventeen (43.6 per cent) considered a program to be effective. However, 21 (53.8 per cent) of these responding physicians declined to express an opinion on this matter.

SUMMARY

The physicians' answers to the questionnaire showed a generally positive attitude toward a PKU detection program, especially by the pediatricians. They expressed some reasons for having a program and offered suggestions to improve a

program. Their merits of a PKU program were that the program would standardize the method of detection, when the tests were to be performed and place the responsibility for testing on all physicians, not just a certain group. They also stated that a PKU detection program would pinpoint at least one cause of mental retardation and if the program detected the very few cases that do occur, some considered their efforts were justified. Their suggestions for improving a program included testing initially, at least 48 hours after the infant was on milk, and each physician visit up to 4 or 5 months of age. Also, a detection program for mass screening of several amino acid abnormalities, PKU included, was suggested.

Some also stated reasons for not having a program. The objections to a PKU detection program were that the time, money and effort invested in a program showed little returns because of the low incidence rate and the few cases detected each year. Objection against legislation making a program mandatory was also expressed.

One significant finding was that 56.4 per cent of the obstetricians and gynecologists and 67.9 per cent of the pediatricians surveyed screened every newborn for phenylketonuria. They apparently felt the need to screen for this disease, even though some objected to a mandatory program.

Their opinions of the dietary treatment for phenylketonuria were generally favorable. However, over half of the physicians who returned the questionnaires failed to express an opinion on this aspect. They felt that dietary treatment as reported in medical literature had not been proved completely successful, and they had not enough experience in their own practice to justifiably express an opinion.

School of Pharmacy (38677)

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## CHANGING TIMES

Mother of a modern teen-ager to friend: "Yes, I always wanted to be the mother of a child with lovely soft long blonde curls—but I assumed it would be a girl."





## MEETINGS

### NATIONAL AND REGIONAL

American Medical Association, Clinical Convention, Dec. 1-5, 1973, Anaheim, Calif. Annual Convention, June 22-27, 1974, Chicago. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Southern Medical Association, 68th Annual Scientific Meeting, Nov. 18-21, 1974, Atlanta. SMA, 2601 Highland Ave., Birmingham, Ala. 35205.

### STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 11-13, 1974, Biloxi. Mrs. Alyce Palmore, Executive Secretary, P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 106th Annual Session, May 6-9, 1974, Biloxi. Charles L. Mathews, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday, March, June, September, December. James S. Poole, The Field Clinic, Centreville 39631, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Max Pharr, B6 Medical Arts Building, 1151 N. State St., Jackson 39201, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, P.O. Box 147, Port Gibson 39150, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday, April, and First Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, P.O. Box 128, Summer 38957, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September and November. J. H. Gaddy, 4502 15th St., Gulfport 39501, Secretary.

Delta Medical Society, Second Wednesday, April and October. Walter H. Rose, 122 E. Baker St., Indianola 38751, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Kenny's Res-

taurant, Hernando. Malcolm D. Baxter, Jr., Baxter Clinic, Hernando 38632, Secretary.

East Mississippi Medical Society, First Tuesday, February, April, June, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian 39301, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez 39120, Secretary.

North Central District Medical Society, Third Wednesday, March, June, September, and December. Robert B. Townes, 1196 Mound St., Grenada 38901, Secretary.

Northeast Mississippi Medical Society, First Thursday, March, June, September, and December. Jack A. Stokes, 207 Holmes Rd., Pontotoc 38863, Secretary.

North Mississippi Medical Society, First Thursday, April and October. Cherie Friedman, 1004 Jackson Ave., Oxford 38655, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. C. Griffing, Crosby Memorial Hospital, Picayune 39466, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, and December. W. C. Welch, P.O. Box 5448, Mississippi State 39762, Secretary.

Singing River Medical Society, Third Monday, January, March, May, July, September, and November. Jeff Hodges, 1365 Market St., Pascagoula 39567, Secretary.

South Central Mississippi Medical Society, Second Tuesday, March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb 39648, Secretary.

South Mississippi Medical Society, Second Thursday, March, June, September, and December. Larry J. Hammett, 2601 Mamie St., Hattiesburg 39401, Secretary.

West Mississippi Medical Society, Second Tuesday, January, April, July, and October, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, The Street Clinic, Vicksburg 39180, Secretary.

# Radiologic Seminar CXXXIV: Ulcer Disease With Retroperitoneal Rupture

KENNETH O. WILLIAMS, M.D.  
Brandon, Mississippi

PERFORATION is the most serious complication of ulcer disease. It occurs most frequently in the pylorus or duodenum and less commonly in the stomach.

Posterior ulcers tend to penetrate the pancreas or lesser sac or dissect into the retroperitoneal space. The most common, however, is an anterior penetrating ulcer which ruptures into the peritoneal cavity.

Rupture into the peritoneal space generally produces a pneumoperitoneum which may be identified within an hour and as little as 2 cc of air can often be demonstrated beneath the diaphragm on an upright chest film.

The patient should be standing or sitting for five minutes prior to obtaining an upright roentgenogram. If the patient is unable to stand, a lateral decubitus is obtained with the patient lying on his left side. Air can then be identified between the liver and the abdominal wall.

In the event that no free air is demonstrated, air can be instilled into the stomach through a tube in those cases where symptoms strongly point to a perforated viscus.

Other causes of roentgen demonstration of free gas within the peritoneal cavity are a ruptured intestine or peritonitis with infection by gas-forming bacteria.

Pneumatosis cystoides intestinalis with rupture of the gas cysts is an uncommon cause as is that following vaginal lavage and idiopathic spontaneous pneumoperitoneum.

## CASE REPORT

A 45-year-old white female was admitted with a history of sudden onset of severe epigastric pain which had occurred approximately 12 hours prior to admission.

She gave no history of prior abdominal pain or ulcer disease.

The physical examination revealed a silent,

boardlike abdomen with generalized tenderness. No other pertinent physical findings were noted.

A recumbent film of the abdomen on admission revealed gas to clearly outline the psoas shadows and renal outlines.

The patient was given Gastrografin orally and films were obtained at one, two, and three hours (see Figures 1, 2 and 3). These revealed contrast media in dilated loops of the small bowel with multiple air fluid levels. The bowel pattern was compatible with an ileus. In addition, there was bilateral excretion of contrast media by the kidneys which suggested leakage through a perforation into the soft tissues or peritoneal cavity.

An upright chest film obtained at this time failed to reveal any free air beneath the diaphragm (see Figure 4).

At surgery the patient was found to have peritonitis involving the retroperitoneal space. A vagotomy and pyloroplasty were performed and the postoperative period was uneventful.

Free gas is normally present in the peritoneum following surgery, but large quantities or an increasing quantity could and probably does indicate a breakdown of an anastomosis following surgery.

This report describes a case of posterior penetrating ulcer which was diagnosed roentgenographically by demonstrating renal excretion of contrast media which was absorbed by the peritoneum and soft tissues after oral ingestion and leakage into the retroperitoneal space.

## CONCLUSION

A case report of a posterior penetrating ulcer is given showing the value of oral administration of absorbable contrast media to indirectly demonstrate leakage into the peritoneal cavity. ★★★

Rankin General Hospital (39042)

## REFERENCES

1. Teplich and Haskin: Roentgenologic Diagnosis, 770, 1971.
2. Paul and Juhl: Essentials of Roentgen Interpretation, 333-336, 1970.

Sponsored by the Mississippi Radiological Society.  
From the Department of Radiology, Rankin General Hospital, Brandon, Miss.





*Figure 1. Thirty minutes after Gastrografin meal.*



*Figure 3. Two hours after Gastrografin meal.*



*Figure 2. Thirty minutes following Gastrografin meal.*



*Figure 4. Upright chest, with no free air visualized.*

# Dr. David Lewis Phares: Member First Mississippi State Board Of Health

BEULAH M. D'OLIVE PRICE  
Corinth, Mississippi

THIS IS THE third in a series of biographical sketches of members of the first Mississippi State Board of Health. The purpose of the series is to assemble data on these members by, or before, 1977 which will be the centennial of the establishment of the board.

David Lewis Phares was born in West Feliciana Parish, Louisiana, Jan. 14, 1817. He was the youngest son of William Phares of Virginia and Elizabeth Starnes Phares of North Carolina. He was graduated from Louisiana State College in 1837 and from the Medical Department of that college in 1839.<sup>1</sup>

Although Dr. Phares was elected to the faculty of his alma mater on the day of his graduation, he declined. Shortly thereafter he moved from West Feliciana Parish to Wilkinson County, Mississippi, where he practiced until 1880.<sup>2</sup> In that year he accepted the chair of biology in the A & M College at Starkville, which position he held until 1889. He had been active in the movement to establish the college.<sup>3</sup>

While living in Wilkinson County, Dr. Phares became in 1852 the first president of Newton College for young men. He served in this position until 1859. The coming of the Civil War forced the school to close in 1861 but it is said that some of its graduates became distinguished in the learned professions.<sup>4</sup>

While serving as a member of the first Mississippi State Board of Health, Dr. Phares wrote an article titled "Synopsis of the Medical Flora of the State of Mississippi." This was published in the "First Annual Report of the Mississippi State Board of Health" in December 1877.

Dr. Phares was vice president of the Mississippi State Medical Association in 1880-81 and president of the association during 1884-85.<sup>5</sup>

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*The author, respected Mississippi historian, gives a brief biography and professional sketch of Dr. David Lewis Phares of Starkville. Among his most distinguished accomplishments were membership on the first Mississippi State Board of Health and serving as chairman of the department of biology at A & M College at Starkville.*

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Dr. Phares was twice married: first to Miss Mary Nesmith of Amite County in 1836. They had three sons and five daughters. Mrs. Phares died in 1876. Dr. Phares was married to Miss Laura Dequercron of Starkville in 1881. They had two sons, both of whom died in infancy. After resigning his professorship at A & M College in 1889, Dr. Phares moved to Madison, Mississippi, where he died on Sept. 19, 1892.

The Mitchell Memorial Library of Mississippi State University has two books by Dr. Phares: *Japan Clover*, published in 1891, and *Farmer's Book of Grasses and Other Forage Plants for the Southern United States*, also published in 1891.

In the same library are articles by Dr. Phares which appeared in bulletins of the Mississippi Agricultural Experiment Station. "Diseases of Sheep and Calves" is in Bulletin No. 9. (Aug. 30,



1889.) "Dishorning" is in Bulletin No. 10. (Oct. 19, 1889.)

In the archives of Mississippi State University are 12 microfilmed items which comprise the David Lewis Phares Collection. Among these are Dr. Phares' diplomas; a photograph of him; and some biographical notes and drawings of the home and college at Newtonia. Two notebooks in the collection are of special interest. One contains "A Catalogue of Pupils Who Have Attended Newton Female Institute," 1842-1851. The second is a medical notebook which was kept while he was at medical school in New Orleans in 1838. The original Phares papers are in the hands of Mrs. Pat Leake of Woodville. The microfilmed copies in the Special Collections Department at

Mitchell Memorial Library were made with her permission.<sup>7</sup> ★★★

P.O. Box 7 (38834)

Note: Previous sketches of members of the first Mississippi State Board of Health by this writer were published in this journal in September 1969 and October 1971. They were articles on Dr. James Marcus Taylor and Dr. Anson Gordon Smythe.

## REFERENCES

1. History of The Mississippi State Medical Association. Second Edition, 1949, p. 67.
2. *Ibid.*, p. 67.
3. *Ibid.*, p. 67.
4. Biographical and Historical Memories of Mississippi. Goodspeed's Pub. Co., 1891, p. 333.
5. History of The M.S.M.A., p. 67.
6. *Ibid.*, p. 67.
7. Statement of Mrs. Judith E. Kirkpatrick, Associate University Archivist, Mississippi State University.

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Rev. Jones was asked to give a talk at a local club luncheon. Tired of religious topics, he gave an inspired talk on the "Minister's View on Sex" and received a standing ovation after. When he got home, his wife was curious about what he had talked on. Knowing what a prude she was, the Reverend mumbled something about sailing and quickly changed the subject. . . . Next day, while shopping downtown, Mrs. Jones met Mrs. Smith who raved about the Reverend's talk. . . . Mrs. Jones remarked, "I really don't know why he chose the subject because he has only tried it twice. The first time, he tried it he kept vomiting and the second time, his hat fell off. . . ."

—*Hawaii Medical Journal*

# Report of the Council on Medical Service: “Medicare/Medicaid Amendments”

SINCE THEIR inception, with the Social Security Amendments of 1965, Public Law 89-97, the federal Medicare and the federal-state Medicaid programs have been matters of continuing concern to the medical profession.

Congressional amendments of varying degree have been effected from time to time since original enactment of both laws. Significant changes in the Medicare program, and less drastic, but still important changes in Medicaid, were enacted in Public Law 92-603, the Social Security Amendments of 1972, and signed into law Oct. 30, 1972. This culminated four years of legislative hearings.

The section of PL 92-603 which has, thus far, received the greatest attention is, of course, Section 249F which authorized Professional Standards Review Organizations (PSROs), the subject of the Board of Trustees Supplemental Report B to the 1973 meeting of the MSMA House of Delegates. However, a number of other sections of PL 92-603 will result in substantial changes in Medicare and Medicaid, and some directly affect past concerns voiced by the MSMA House of Delegates.

The Council on Medical Service therefore feels it appropriate at this time to present a general report on Medicare and Medicaid to indicate to the profession some of the future directions these programs may take and as a “progress report” on some of the continuing concerns expressed by members of the association.

This is by no means intended as a comprehensive “Guide to Medicare or Medicaid,” but is rather a review of certain selected facets of the program, the choice being based on three criteria: those matters which have been the subject of reports or resolutions to the MSMA House of Delegates in recent years; those which have been brought to the council's attention through correspondence from individual physicians; and those which the council, in its review of PL 92-603, believes to be of potential major concern to the medical profession.

Finally, the council wishes to emphasize that the regulations which will put the flesh on the statutory skeleton of PL 92-603 are, in many respects, not yet complete.

## MEDICARE

*Eligibility.* The number of individuals eligible for care under Medicare was increased substantially by the addition in July 1973 of some 25,000 Social Security disability beneficiaries in Mississippi who became eligible for Medicare after 24 months on the disability rolls. This group will comprise about 10 per cent of the total Medicare enrollment in Mississippi and will undoubtedly result in some significant changes in the type of care provided—and even of the specialties providing care—since not only are these disabled persons expected to require significantly more care than the present aged recipients of Medicare, but also they will include all age groups, including children disabled before reaching the age of 22.

The medical profession should be aware, however, that not *all* the disabled will be eligible for Medicare, but only those eligible for cash disability benefits under Social Security, and only after at least 24 months on those disability rolls.

Patients suffering from chronic renal disease requiring dialysis or transplants will also be classified as “disabled” and will become eligible for all Medicare benefits after three months on dialysis. In numbers, this group is comparatively small but because of the high continuing cost of dialysis, the program is expected to attract special interest.

*Physician Reimbursement.* As the profession is aware, the concept of payment of a “reasonable charge” for physicians' services embodied in the law has been progressively modified by Bureau of Health Insurance (BHI) directives and, currently, by Price Commission controls. At present, federal regulations and directives define a physician's “customary charge,” for Medicare purposes, as his median charge for a given service



during the calendar year preceding the current federal fiscal year—i.e., a dollar amount which would cover his fee in at least half the instances the service was performed during 1972 for the fiscal year beginning July 1, 1973.

The “prevailing charge” for the community, which sets the ceiling on reimbursement for all physicians in the community, is now defined as the 75th percentile of customary charges, weighted by the frequency with which each physician performs the service—i.e., a dollar amount which would cover the charge for the given service 75 per cent of the times it was performed during the calendar year if each physician actually charged, in each instance, his Medicare calculated “customary charge.”

Medicare “reasonable charges,” using this calculation, establish a level of payment which, in many cases, is significantly below what the physician is actually charging non-Medicare patients currently. However, Price Commission rulings have further restricted Medicare allowances, by defining the Medicare “reasonable charge” screen as a “price list” and applying to the screen itself the 2.5 per cent limitation on increases in physicians’ charges. Because of this Price Commission requirement, Medicare can, at present, recognize only a portion of the annual increase in prevailing charge levels which would take place if only the Medicare formula were in effect.

The profession has protested strongly, and continues to protest both Medicare’s arbitrary determination of “customary” and “reasonable” charges, and the discriminatory application of price controls to the medical profession.

PL 92-603 imposes a new statutory limitation on increases in physician reimbursement under Medicare. Beginning in July 1973, the prevailing charge screen by law will increase only to the extent that such increase is justified by “economic changes” measured by “appropriate economic index data” gathered by DHEW. The law does not spell out the factors which will be part of the “index,” but congressional reports suggest a formula which takes into account increases in the physician’s cost of doing business and earnings increases in the general population.

It is clear, however, that from this point, while some physicians’ Medicare reimbursement may rise as their non-Medicare charges rise, the “prevailing charge” ceilings on Medicare reimbursement will no longer bear any direct relationship to what physicians actually charge.

The question of what “economic indexes” will be applied is now under exploration by DHEW and the Federal Office of Management and Budget.

et. However, since the restrictions imposed by the Price Commission result in a reimbursement level below the prevailing charges which would be authorized by PL 92-603, federal officials do not consider development of these indexes a priority item at present.

*Physicians in Teaching Hospitals.* When Medicare was enacted, there was nothing specific in the law concerning billing by physicians in teaching settings. Payment of interns and residents was considered part of the hospital expense, to be reimbursed under Part A; payment under Part B to the attending physician was based on a requirement that he give personal attention to the patient. Considerable confusion resulted with, in some areas, new billing approaches to seek Part B reimbursement for physicians’ services to teaching patients.

Section 227 of PL 92-603 establishes a new approach to determining the source and amount of physician reimbursement for patients in a teaching setting. Basically, what it attempts to do is distinguish between private patients, for whom care will be paid under Part B on a “reasonable charge” basis, and non-private teaching patients, for whom care will be paid under Part A as a “reasonable cost” of the hospital.

The law specifies that the “private patient” type payment will be made where the hospital, since the start of Medicare, has been routinely billing and collecting for services to Medicare and non-Medicare patients alike for the services rendered by physicians. Other criteria for determining who are “private patients” are left to DHEW, but some indicators suggested by Congress are attendance by a particular physician out of the hospital and in the institution.

It should also be noted that, where physicians’ services are considered part of the teaching program, the payment to the hospital, on a “reasonable cost” basis, is to go into a fund designated by the organized medical staff of the hospital or, if services are furnished by a medical school, by the faculty for improvement of care or for educational or charitable purposes. Payment to the fund for physicians’ services can be made, on an agreed reasonable cost basis, even when the hospital incurs no actual cost for such services, as when a physician participates in a teaching program on a voluntary basis.

*Retroactive Denial.* For the past several years, remedies to reduce the instances where a paid claim for institutional services has, on subsequent review, been found to be improperly paid, have been sought. In such instances, the paid claim becomes an “overpayment,” subject to recovery

## AMENDMENTS / Continued

from the facility by Medicare, with consequent problems for the hospital or nursing home, the patient (who thereby becomes newly liable for the charge), and the physician who is often blamed for the confusion. There has been no "statute of limitations" on when such review could occur.

Of the statutory changes in this area, perhaps of most immediate significance is the enactment of Section 281, PL 92-603, which establishes a *three-year statute of limitations* under which, if an incorrect payment for custodial care or services found not medically necessary is discovered over three years after payment was made and the recipient was without fault in claiming the payment, no recovery will be made. While this is still a rather lengthy liability period, it is a substantial improvement over the prior situation when all paid claims, from the first day of the program, were liable to recovery. In addition, the law gives DHEW authority to reduce the three-year period to one, if it can be done without detriment to program objectives. BHI officials desire experience with the three-year statute before considering any reduction of the time.

A second change was made by Section 213, PL 92-603, which will provide relief in individual cases where, after payment, it is determined that care rendered by a physician or institution is medically unnecessary or custodial, by Medicare standards. A *waiver of liability* is allowed, on a one-time basis, where the physician or the provider and the patient submitted the claim in good faith with the expectation that Medicare would cover it; i.e., Medicare will not seek to recover the amount "overpaid," but will notify the parties involved of the reasons why the service would not ordinarily be covered and that the waiver will not be applied in future similar instances. This procedure not only protects the participants from unexpected expenses when they have acted in good faith, but will also provide an educational mechanism so that physicians, providers, and patients will have a clearer understanding of what Medicare does cover.

This section does, however, pose some potential problems for providers and physicians, although it applies only to physicians who have accepted assignment and will not affect those using direct billing. The "waiver of liability" applies only when all parties act in good faith and with due care; if a provider or a physician who accepts assignment submits a claim which he could be reasonably expected to know is not covered, the claim (if paid) is considered an "over-

payment" and is subject to recovery. Further, if a provider or physician, knowing that Medicare will not pay, collects from a patient, the amount he has paid will be refunded and recovered from the provider or physician.

In the usual pattern of assignment billing, the last procedure above will seldom apply. It could arise, however, when a physician had collected part of his charge from the patient and accepted assignment on the rest or under other unusual circumstances. It appears only common sense that the physician who accepts assignment should inform the patient in advance if there appears some doubt whether Medicare will approve payment. BHI guidelines for this section are still being developed, but BHI expects it will be applied initially in only the most obvious and clearcut cases.

A third change in the law, Section 228, PL 92-603, authorizes *advance approval of length of stay* in skilled nursing facilities and home health programs. This follows the concept of an "assurance of payment" program for extended care facilities (now renamed "skilled nursing facilities"). For specified diagnoses, BHI will authorize payment for at least a specified period of time, based on the condition of the patient at time of admission.

Development of this procedure is already under way. BHI medical staff has been working with physicians and with providers to develop descriptors and average lengths of stay for a group of diagnoses which cover some 60 per cent of the admissions to skilled nursing facilities. Using this list, if a physician certified the need for services and one of these diagnoses, payment would be guaranteed for a specified length of time, unless the utilization review committee decided the patient should be released earlier.

It should be emphasized that this is *not* a "ceiling" on the number of days' care which will be reimbursed but rather, for these conditions, a "floor." Additional days of care will be approved on the usual basis of medical justification for continued stays. Indeed, since the guaranteed stay will, in many cases, be less than the average stay for the condition, patients will be expected to stay longer.

As to BHI administrative actions, BHI officials have expressed the intention of shifting more responsibility for coverage decisions to utilization review committees. As the profession knows, the utilization review committee now has, by law, the authority to terminate Medicare payment for inpatient services to those patients for whom they consider further institutional care medically unnecessary. However, the Medicare carrier has had



the authority to ignore a review committee's decision that continued institutional care *is* medically necessary.

Medicare officials have expressed the opinion, under the waiver provision, Section 213, PL 92-603, that the matter of whether an institution has exercised due care in submitting claims will depend, in large part, on efficacy of its utilization review committee. They see a possible shift to basing reimbursement on the reliability of the review committee, rather than on intensive carrier review of individual claims.

Similarly, Section 213 provides a *right of appeal* by a provider or by a physician who has accepted assignment against a carrier decision that billed care is medically unnecessary or custodial, to the same extent that the recipient already has such right of appeal. While this appeals process only allows reconsideration and hearing by the carrier, rather than BHI, it is at least a step forward.

It should be noted, perhaps, that the PSRO networks, once implemented, while having many potential drawbacks, may also provide physicians with significantly more assurance as to what Medicare and Medicaid will cover, as well as a structured mechanism for appeal of all decisions with which they disagree.

*Hospitalization Standards.* Two other requirements for hospital care under Medicare Part A have attracted considerable interest on the part of the medical profession. Almost since the beginning of the program, the association has opposed the statutory requirement that a physician *certify and recertify* the need for hospitalization. When the law was first enacted, it required that initial certification be at the time of admission to the hospital; this admission certification has been eliminated, but the law still required certification and recertification at such times as set forth in regulations—currently, no later than the 12th and 18th days.

The association has urged that the certification and recertification requirements be deleted from the law on the basis that they serve no useful purpose and simply add to the physician's paperwork for the program.

However, it remains a statutory requirement of the Medicare program and the only present legislative authority under which it can be dropped lies in a section of the PSRO legislation which authorizes DHEW to eliminate other types of controls when it finds that the PSRO functions to the same effect. Since Title XI (the Professional Standards Review title of the Social Security Act) requires PSROs to establish points in time,

consistent with the average lengths of stay for given illnesses and types of patients, at which physicians will certify the need for continued institutional care, it is assumed that PSRO certification will tend to supersede current Medicare certification procedures.

Another hospital-oriented problem with Medicare has been the requirement that "*a physician sees*" all patients arriving for treatment in the emergency room. The objection is not to a physician's assuming professional responsibility for the care of those coming to the emergency room, but to the requirement that he physically "see" each such individual. With many patients using the emergency room for non-emergency elective care, the current requirement does not allow the physician on call for emergency service to decide on the basis of information from the emergency room staff whether a particular patient requires his immediate presence and results in a waste of physician time. BHI officials have agreed to reconsider the wording of this section of the regulations.

*Skilled Nursing Facilities.* As previously noted, the term "extended care facilities" or "ECFs" in Medicare legislation has been replaced by PL 92-603 with "skilled nursing facilities"; the same term replaces "skilled nursing homes" in Medicaid legislation (Sec. 278).

While there is no significant change in the concept with the change in name, the new legislation may result in some expansion of coverage through two changes. The basis for Medicare reimbursement of post-hospital care in a skilled nursing facility remains the need of the patient, on a daily basis, of "skilled nursing services provided directly by or under the supervision of skilled nursing personnel, for the conditions for which he was hospitalized. This is essentially the definition previously in effect for extended care services, with the reimbursement decision made on the basis that such services or supervision could be provided *only* by skilled professional nursing personnel, not by a lesser category of para-professional or auxiliary personnel.

However, the law now also recognizes the need for "skilled rehabilitation services" as a basis for reimbursement in skilled nursing facilities. It does not spell out what such services may be; regulations will probably attempt to define rehabilitation services which need a degree of professional skill equivalent to that required for skilled nursing services.

The second change may prove more significant. It extends coverage to skilled nursing care, as previously defined, and skilled rehabilitation services which, "as a practical matter," can only be pro-

## AMENDMENTS / Continued

vided in a skilled nursing facility on an inpatient basis. Medicare officials have not yet developed any criteria for deciding when, as a practical matter, inpatient care is necessary. It is reasonable to assume, however, that this wording in the law will result in some shift of emphasis from approving reimbursement for inpatient services only when, ideally, inpatient status itself is essential to the type of care provided to considering the practical availability—or unavailability—of outpatient sources of the care needed.

### MEDICAID

Over 50 sections of PL 92-603 affect Medicaid, the federal-state grant-in-aid program of medical assistance to the needy. The most significant trend in the numerous changes is an increasing correlation between Medicare and Medicaid. Some correlation between the two programs existed, by regulation, prior to the enactment of PL 92-603. For example, states were not permitted to pay physicians more under Medicaid than the "reasonable charge" under Medicare, although a lower rate of payment was permissible, and "skilled nursing homes" under Medicaid were expected to meet the same standards as "extended care facilities" under Medicare.

Now these and a number of other provisions are a matter of law, rather than regulation. For example, the formula for limitations on prevailing charges in Medicare discussed earlier also applies to Medicaid and, as mentioned earlier, the term "skilled nursing facility" has been substituted for both "extended care facility" in Medicare and "skilled nursing home" in Medicaid, and the same level of care definition applies in both programs. PSROs will review both Medicare and Medicaid cases, applying the same standards to both. Similarly, throughout PL 92-603 there are many new provisions which will apply to both programs. It may be presumed that, in many instances, the Medicare agency, with its greater experience in direct supervision of health care financing, will tend to be the lead agency in regulations and guidelines applying to both programs.

Following are some of the more significant changes in Medicaid as identified by the Council on Medical Service:

**Eligibility.** PL 92-603 establishes a new income maintenance program, which will replace the present adult public assistance categories (Old Age Assistance, Aid to the Blind, Aid to the Permanently and Totally Disabled) as of January 1974. The program will be federally financed and

administered through a new bureau of supplemental security income in the Social Security Administration and will provide each eligible individual with a minimum income of \$1,680 per year, or each couple, both of whose members are eligible, with a minimum income of \$2,520 per year.

This has a potential for an increase in Medicaid recipients in Mississippi. States will have the option of including all this group in their Medicaid programs, or of limiting the program to those eligible by January 1972 state standards; however, if they choose the latter, they must include the medically indigent who have reduced their income to the January 1972 limits through medical expenditures. Legislation was proposed without success during the 1973 regular session of the Mississippi legislature to apply the new federal standards for Medicaid eligibility.

States are also prohibited from using the 1972 increase in Social Security benefits as a basis for dropping aged individuals from the current assistance rolls. On the other hand, inclusion of the disabled under Medicare if they are eligible for Social Security benefits will transfer some expenditures from Medicaid to Medicare.

**Benefits.** There has been little liberalization of benefits. Family planning is now mandatory in Medicaid programs and states which do not implement the screening-diagnosis-treatment program for children will be penalized by reduced federal matching after mid-1974. Psychiatric care for those under 21 is also included at state option.

Some of the changes, in fact, may tend to restrict Medicaid benefits. A requirement in the federal law since its enactment in 1965 which called for broadening the scope of Medicaid benefits to achieve "comprehensive" care by 1975 (later changed to 1977) has been deleted, as has been a prohibition on reduction of Medicaid expenditures from one year to the next. In addition, cost-sharing provisions have been added: for the needy, a "nominal" copayment is permitted for those services not mandated by federal law, and for the medically needy, the state is not only permitted to require the "nominal" copayment, but it is also required to charge an income-related premium for Medicaid coverage.

**Administrative Changes.** As noted, PSROs will assume review responsibility for Medicaid. Until such time as the PSRO takes over, Medicaid is to use the same utilization review committees as Medicare unless Medicaid can demonstrate its review is more effective; matching for institutional stays will be reduced one-third after they exceed specified periods unless the institution can demonstrate effective utilization controls.



DHEW also now has authority to terminate payment to specific providers and physicians found to be "abusing" the program, and federal penalties for fraudulent claims are spelled out; previously, this was a state responsibility. Under one peculiar correlation between Medicare and Medicaid, Medicaid can be used to reinforce Medicare controls; if Medicare has difficulty recovering "overpayments" from providers, no Medicaid payments will be made to those providers.

Medicaid now also includes funding authority for data processing systems to handle Medicaid claims, up to 90 per cent of the cost of establishing such systems and up to 75 per cent of the cost of operating. Federal directives to date clearly indicate that these funds need not be used solely to finance systems for which the state contracts with

non-governmental agencies. However, no funds have yet been specifically appropriated for this section of the law.

## CONCLUSION

The Council on Medical Service presents this report as an informational document. The council wishes to emphasize again, and strongly, that this is far from a complete résumé of the hundreds of changes made by PL 92-603 and can be considered only a preliminary assessment of these changes since, in many cases, the regulatory language has not yet been published—let alone finalized. ★★★

JACK A. ATKINSON, M.D., Chairman  
Council on Medical Service

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## A JUST REWARD

Bill and Bob, two midwest doctors, returning from a duck hunting trip in the south had car trouble and were forced to spend the night at an elegant old plantation home of a handsome young widow. . . . The widow put them up for the night, provided a sumptuous supper with after dinner brandy. . . . Next day, they found their car repaired as promised and they thanked the widow and went their way. Nine months later, Bill called Bob. "Say Bob, do you remember the night we spent at the widow's home?" "Yes?" replied Bob cautiously. . . . "Did you by any chance visit her after we had gone to bed?" "Yes." "Did you by any chance use my name?" "Yes, Bill, but I hope I didn't get you into any sort of trouble?" "No, Bob, I just learned that she had died and left me her entire estate."

—*Hawaii Medical Journal*



# The President Speaking

## “The Needs of the Elderly”

ARTHUR A. DERRICK, JR., M.D.

Durant, Mississippi

I HAVE PUT some thoughts together on the needs of the elderly in Mississippi and the services available to them. Here they are for what they are worth.

The foremost need, I feel, is respect. Among the many profound changes in our present-day manners and mores—and they are profound!—is this loss of respect and veneration of our elders. Witness the orientals, with their deeply-ingrained respect for “venerable ancestor.” They seem to be doing all right. We place the “accent on youth” in a wild fruitless effort to remain young, frantically resisting the inexorable slide into time. Look at the unbelievable number of items produced by the cosmetic industry, constantly smeared on us through the media; the sophomoric styles, as ludicrous as any “zoot-suit”; hair transplants; mammo-plastys, etc. ad infinitum. What happened to “grow old gracefully”?

Do we recognize the unpayable debt we owe them? I doubt it. Now they are albatrosses around our necks. One feeble gesture, then zap! into the nursing home, that way station between this earth and whatever!! The waning spark is doused by an unbelieving feeling of desertion. The Medicare rug pulled out from under them, they realize that they have become hapless financial burdens. They lie in countless conglomerates amid the uriniferous sick-sweet necrotic smell, in drugged apathy, perhaps relishing easeful death.

Few problems are insoluble in this age of automation. Is this one? ★★★





## Continuing Medical Education In Mississippi

The continuum of medical education is one of those notable topics on which all physicians agree. Its acquisition may begin with the college "pre-med" program, but the need for continued knowledge does not end a few years later with the bestowing of an M.D. degree. The years of medical practice beyond the school setting are filled with problem cases, some unanswerable. It is these cases which can, and do, provide an excellent background for continuing medical education.

Physicians are primarily concerned about continuing medical education from two viewpoints: convenience, or time involved, and relevancy to everyday medical practice. With these points in mind, the Mississippi State Medical Association through its Council on Medical Education submitted an application to the American Medical Association to become the accrediting agency for continuing medical education in Mississippi. Final approval from AMA is still several months away, but work has already been initiated by MSMA committees. Prior to submitting the application or "Plan" to AMA, approval was obtained from the MSMA House of Delegates at the 105th Annual Session, Biloxi, 1973.

As their goal, the Council on Medical Education and its *Ad Hoc* Committee on Continuing Medical Education intend to assist in developing local community hospital continuing medical education programs for physicians. Initial development of a regional continuing medical education program in community hospitals has been facilitated through funds from the Mississippi EMCRO. This pilot CME program is a beginning

for Mississippi in the effort to provide CME on a local basis. The Tyler Holmes Memorial Hospital in Winona, Grenada County Hospital in Grenada, and the Greenwood-Leflore Hospital in Greenwood are presently participating in this pilot CME program. The Mercy Regional Medical Center in Vicksburg is also participating in a pilot project for continuing medical education based on the single hospital approach. Both programs identify possible CME needs through the Mississippi EMCRO summaries. This method for evaluating the quality of medical care also gives each of the hospitals mentioned a method for improving the quality of care.

After these two programs are developed, a three member survey team from the Mississippi State Medical Association, appointed through the Council on Medical Education, will consult with representatives of each hospital. Following this consultation-survey meeting, accreditation will be recommended for a given number of years. The end result of the above mentioned efforts is a continuing medical education program for community hospitals with local scope and focus.

Inquiries regarding continuing medical education and its accreditation should be forwarded to the Mississippi State Medical Association, 735 Riverside Drive, Jackson 39216. Interested persons might refer to a manual entitled, "Continuing Medical Education in the Community Hospital" by N. Stearns, et al.

Council on Medical Education  
Mississippi State Medical Association

## "HMO Overview"

Although the Health Maintenance Organization (HMO) movement has become fashionable in recent years it has been around since the late 1920's. Such prototypes as the Ross Loss Medical Clinic (1929), Group Health Association (1937), Group Health Cooperative of Puget Sound (1946), the Health Insurance Plan of Greater New York (1947), and the San Joaquin Medical Care Foundation (1954) provided much of the early leadership in what has become a widespread activity.

The term "HMO" encompasses quite divergent forms of organization. In the classical sense, an HMO is considered to be a closed-panel group practice providing 24 hour comprehensive medical services to its enrollees on a prepaid basis. The acknowledged example of an HMO in this classical sense is Kaiser-Permanente, which is now the world's largest private prepaid group health plan.

Most HMO concepts involve a four party relationship: sponsors, facilities, practitioners and enrollees. In most instances, the contractual relationship between all parties will depend upon local enabling statutes and the nature of the organizational structure. Ordinarily, the plan entity is separated from the practitioners in order to minimize lay participation in the provision of care.

On the other spectrum of the HMO concept are the Foundations for Medical Care, as pioneered by the San Joaquin Foundation for Medical Care. It is said that the possibility of the Kaiser Medical Foundation, a prepaid group practice, expanding into the San Joaquin Valley disturbed valley area physicians in the early 1950's to the extent that they formed the San Joaquin Foundation for Medical Care to counteract what they considered to be a threat to the solo practice of medicine. Their desire to incorporate some of the attractive features of Kaiser with private medical practice resulted in a medical society-sponsored, open-paneled, group insurance plan under which physicians would be reimbursed on a fee-for-service basis, as opposed to Kaiser's close-paneled, prepaid group practice plan.

As a result of San Joaquin's pioneering efforts many state and local medical societies and associations have formed their own foundations for medical care, and many of these have since opted

to establish their own fee-for-service, group health plans which are considered to be "HMO's without walls."

Regardless of the form they take or the relationships between participating parties, the federal government has, through enactment of fairly recent legislation, provided a fiscal impetus for the creation of still more HMO's in addition to the nearly 346 which are now in either the developmental or operational stage throughout the country.

Public Law 92-603, which was enacted in November 1972, contained a provision which provided statutory recognition of HMO health care for Medicare beneficiaries and an authorization for furnishing technical assistance to any state Medicaid program interested in contracting with an HMO.

More recently, both houses of the 93rd Congress have passed their own HMO bills. The Senate-passed HMO bill, S.14, was sponsored by Senator Edward M. Kennedy (D.-Mass.) and authorized grants for planning and feasibility studies, initial development costs, construction, and initial operation costs at an appropriation price tag of \$850 million. The purpose of this bill is principally to aid HMO development through a fiscal year 1974-76 program of grants and loans to potential or existing HMO sponsors.

The House-passed bill, H.R.7974, otherwise known as the Roy-Rogers bill, was sponsored by Congressmen William R. Roy (D.-Kan.) and Paul G. Rogers (D.-Fla.). Unlike the Senate version, the Nixon-backed House bill authorizes a five year (FY 1974-78) program of experimental and demonstration projects with emphasis on feasibility studies at an appropriation of \$240 million.

Conferences of the House and Senate began meeting on Oct. 9 to iron out the differences between the two versions. Most observers feel that conference committee debate will center around not only a compromise between the \$850 million, 3 year Senate appropriation and the \$240 million, 5 year House appropriation, but also two issues generally opposed by organized medicine: namely, the Senate bill provisions calling for pre-emption of state laws which prevent operation of an HMO and the creation of a Commission on Quality Health Assurance that many feel is an unnecessary duplication of PSRO. Interstate and Foreign Commerce Committee Chairman Harley Staggers (D.-W. Va.) has indicated that he and the other House conferees would stand by the House-passed version in seeking a compromise. In addition,



President Nixon has stated that he would veto any HMO bill which did not provide for demonstrations and experiments and whose price tag is more than \$240 million. Consequently, the final conference report will probably approximate the House-passed bill since most conferees do not want to align themselves behind any HMO bill which would likely be vetoed.

In Mississippi, one physician-sponsored HMO is off the drawing board in Vicksburg and another industry-sponsored closed-panel HMO is rumored for the Gulf Coast area. At present, there are not enough facts available to report on the latter, but the Street-Mercy Family Health Plan in Vicksburg evolved over the past few years from a study conducted under a feasibility and impact grant which revealed a high potential for an HMO in the area.

The S. and M. Family Health Plan, as it is commonly called, is headed by a seven member board of which Dr. John R. Shell is chairman. It is scheduled to become operational on July 1, 1974, and will offer a total package of health care services for a predetermined capitation payment. In addition to physician and hospital services, nursing home services in a 15-bed hospital-based ECF will be included in the total package pending approval of the facility.

The plan has recently employed a marketing director and anticipates a successful enrollment campaign based on its ability to provide complete health care to a defined patient population for a monthly premium which is competitive with commercial insurance. The Vicksburg S. and M. Family Plan will be described in detail in a future issue of the JOURNAL MSMA.

WILLIAM F. ROBERTS, J.D.  
Executive Assistant, MSMA

## Involvement

In these unprecedented times when every informed person is aware of the many crises that face our society—pollution, overpopulation, welfare programs, ever increasing taxes and continuing inflation—it seems apparent to me that, in those areas particularly that we can speak about with more than a modicum of authority, we need to be involved and heard.

While our first concern is the delivery of health care, we as a profession are probably well qualified to be heard on population control and it is time we become concerned with *quality* as well as quantity control.

As government becomes larger and more cen-

tralized we have an increasing sense of impotence to affect any change. The bureaucracy that expands each year and is virtually outside the control of our three branches of government further increases our sense of frustration.

Despite these things there are a lot of good things about our government and our society, and few would trade it for any other government known.

If we in the profession can't affect reasonable birth control in the retarded, mentally ill or hereditary illnesses resulting in non-productive progeny, it is conceivable that in less than a generation some forceful measures may well be instituted.

W. MONCURE DABNEY, M.D.  
Editor  
Crystal Springs, Miss.

## Measles Morbidity and Mortality in Mississippi

Even though measles is currently a vaccine-preventable disease, cases of this potentially fatal exanthem are still currently occurring in the state. In the first 9 months of 1973, 59 cases of measles have been reported. Fortunately, there have been no fatalities reported in 1973; however, 61 deaths due to measles occurred in Mississippi children during the 10-year period from 1963 to 1972.

Since the introduction of measles vaccine in the late 1960's the number of reported cases of measles has declined markedly. After the introduction of measles vaccine, a drop in the number of reported cases occurred from 1966 to 1970, but a marked increase in reported measles occurred in 1971. Two deaths due to measles were reported that same year. Continued efforts are needed to further control measles in Mississippi. Our division participated in the national Immunization Action Month (IAM) as part of a cooperative national effort to reverse the alarming trend of declining immunization levels among preschool age children against the major vaccine-preventable diseases.

Private physicians can be of vital assistance in eliminating measles from Mississippi by reporting *each and every case* of measles that they see. Each individual case will be investigated by a field worker in the immunization section. The investigator will review the immunization records of the case and childhood contacts and will plan further action (such as a local immunization clinic) if it is indicated. The usefulness of this approach was emphasized in recent outbreaks in Perry and Pike

EDITORIALS / Continued

counties.<sup>2</sup> Physicians are asked to call reports (collect calls will be accepted) to either Mr. Paul Turner (354-6637) or to the Division of Preventable Disease Control (354-6650).

DANIEL J. SEXTON, M.D.  
State Board of Health

REFERENCES

1. Mississippi Weekly Morbidity Report, No. 7, Feb. 16, 1973.
2. Mississippi Epidemiology Notes, Vol. No. 1, Jan., 1973.
3. Mississippi Weekly Morbidity Report, No. 23, June 8, 1973.

The Art of  
Human Stitchery

The following poem was written by Dr. James Ronald Bartlett, associate professor of German at the University of Mississippi, after he underwent surgery performed by Dr. Joseph E. Roe of Oxford. Dr. Bartlett says, "Knowing how I myself often get very bored with the *routine*, it is easy to imagine a surgeon also seeking release from that same boredom by embellishing the straight stitch with a few extra flourishes! In any case, I still deny that this was the result of the anesthetic! (Even the attending nurse suggested, however, that if put to the wall, I should use that as the excuse.)

THE ART OF HUMAN STITCHERY  
(with apologies to the Poetic Muse)

The Art  
of Human Stitchery  
is putting stitches  
where it itches  
a pleat of folded skin  
a stitch without  
a stitch within  
herringbone or crosspatch bold  
the only question is—  
    *will it hold!*  
Having done ablation  
    at the Temple  
    of Hippocrates  
        he's now intent  
        on putting people's  
pain at ease  
by  
practi'skin  
        embroideries . . .  
But goodness, what is this?!!

By jelly!  
Oh! Oh!

There it is across my belly—  
    *Roe! Roe!*  
spelled out in bold black thread  
embroidered stitches where I bled!  
But today we'll have one last bout  
He'll have to take the blamed things out!  
There's really little consolation though  
for surely surely

*tic tac toe*  
    the scars forever  
    will spell—

ROE!



THE MISSISSIPPI POSTGRADUATE  
INSTITUTE IN THE  
MEDICAL SCIENCES

Jan. 7-11, 1974

ELECTROCARDIOGRAPHY INTENSIVE COURSE  
University Medical Center, Jackson  
Jan. 7-11, 1974, beginning at 9:00 a.m.

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program  
Coordinator:

Thomas M. Blake, M.D., professor of medicine,  
The University of Mississippi School of Medicine

Selected for their immediate applicability, topics in this one-week course will be supplemented by use of electrocardiograms, slides and other visual aids. Participants will interpret electrocardiograms and join in conferences.

All the intensive courses are offered through the University of Mississippi Medical Center, with partial support from the Mississippi Regional Medical Program, The Kidney Foundation of Mississippi, Inc., the Lilly Research Laboratories, the Bristol Laboratories, G. D. Searle and Company, and private donations. The courses are open to all Mississippi physicians. A registration fee of \$100.00 is charged.

FUTURE CALENDAR

Jan. 7-11, 1974

ELECTROCARDIOGRAPHY INTENSIVE COURSE  
May 6-9

MISSISSIPPI STATE MEDICAL ASSOCIATION,  
BILOXI





## THE LITERATURE

### Book Review

**The Cardiac Arrhythmias. Second Edition. By Brendan Phibbs, M.D., with contribution by Gordon A. Ewy, M.D. 205 pages with 264 illustrations. St. Louis: The C. V. Mosby Co., 1973. \$7.50 for the paperback edition.**

The knowledge that there is a new EKG manual on the market has the same effect on most physicians as would the knowledge that there is a new laxative on the market. From the number of good cardiology texts and EKG manuals and primers presently available, my first impression was that there was really no need for another manual, even one that supposedly dealt only with the cardiac arrhythmias. However, this definitely was a mistaken impression as this particular manual is quite distinctly different from any previous ones. In the preface the author mentions, "if the book has a virtue, it is simplicity." This is very definitely its greatest virtue although there are several others. It is extremely relaxing to read a book when common everyday language is used to describe a simple mechanism that usually is described in much more detailed, confusing scientific jargon.

The book is basically divided into four parts, the first 10 pages of which comprise Part I consisting of a brief review of basic anatomy and physiology. Part II consists of the simple arrhythmias such as ectopic beats, ventricular aberration and ventricular fusion and atrial flutter and fibrillation. Part III comes to the more complex arrhythmias such as the digitalis induced arrhythmias, the so-called "sick sinus syndrome," and arrhythmias that are frequently seen in coronary care units. The last section consists of drugs and techniques including pacers and defibrillators. The discussion of the different drugs used in treating cardiac arrhythmias is particularly good, especially in regard to digitalis therapy.

Following the part about simple arrhythmias and the part about complex arrhythmias, there are two review chapters to check the reader on problems, practice and reinforcement. These are particularly good since most readers get the impression from reading other EKG manuals that all arrhythmias are easily classified according to certain simple, set rules. This, of course, is definitely not true in actual practice and in these two

chapters the reader not only becomes aware of the different variations of arrhythmias but also some suggestion as to cause, prognosis, and treatment.

The biggest problem a reader has with this text is with the illustrations. Many of the EKG strips were not reproduced with enough contrast. Several are quite small, measuring less than one centimeter in width. Frequently the EKG illustration will be on one page while the interpretation will be on a reverse page, necessitating turning the page from side to side. It would also have been helpful had the particular complexes been numbered. At times the author refers to the 15th and 17th beats which necessitate counting back to determine which beats he is discussing. Hopefully this will be corrected in future editions.

All in all, this is an excellent up-to-date text regarding arrhythmias, their interpretation and treatment.

WALTER T. TAYLOR, M.D.  
Clarksdale, Miss.



## NEW MEMBERS

ALLEN, S. M., Quitman. Born Laurel, Miss., on Sept. 22, 1947; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1972; interned Memorial Medical Center, Savannah, Ga., one year; elected by East Mississippi Medical Society.

BROWN, RONALD LEE, Gulfport. Born Evansville, Ind., on May 5, 1939; M.D., Indiana University School of Medicine, Indianapolis, Ind., 1966; interned Indiana University Hospital, Indianapolis, Ind., one year; urology residency, same, 1969-1973; elected by Coast Counties Medical Society.

EDWARDS, JOHN BERLYN, Biloxi. Born Plattsberg, Miss., on Dec. 31, 1935; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1960; interned Brooke General Hospital, Ft. Sam Houston, Tex., one year; surgery residency, same, 1961-65; plastic surgery residency, Walter Reed General Hospital, Washington, D. C., 1965-67; fellowship, same, 1967-68; elected by Coast Counties Medical Society.

## NEW MEMBERS / Continued

GLASGOW, THOMAS SENTER, Grenada. Born Pryor, Okla., on Feb. 21, 1942; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1968; interned Hillcrest Medical Center, Tulsa, Okla., one year; family practice residency, McClennan City Medical Society Family Practice Residency program, Waco, Tex., 1971-73; elected by North Central District Medical Society.

GRIFFIN, RUBY B., Calhoun City. Born Calhoun City, Miss., on Aug. 7, 1934; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1962; interned Baptist Hospital, Nashville, Tenn., one year; surgery residency, same, 1963-64; elected by Northeast Mississippi Medical Society.

MCDEVITT, ELLEN (RET), Gulfport. M.D., University of Utah College of Medicine, Salt Lake City, 1949; interned Meadowbrook Hospital, Hempstead, N. Y., one year; elected by East Mississippi Medical Society.

MCEACHIN, LAWRENCE BENJAMIN, Meridian. Born Grenada, Miss., Sept. 11, 1942; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1967; interned, same, one year; dermatology residency, University of Virginia, Charlottesville, Va., 1968-71; elected by East Mississippi Medical Society.

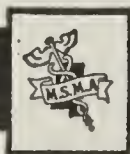
NELSON, NORMAN C., Jackson. Born Hibbing, Minn., on July 24, 1929; M.D., Tulane University School of Medicine, New Orleans, La., 1954; interned Charity Hospital, New Orleans, La., one year; surgery residency, same, 1958-62; vice chancellor for health affairs and dean of University of Mississippi School of Medicine, Jackson, Miss.; elected by Central Medical Society.

PHILLIPS, SAMUEL, Jackson. Born New York, N. Y., on Jan. 16, 1908; M.D., Medical School University of London, London, England, 1935; interned Trinity Hospital, one year; internal medicine residency, Tuberculosis Grasslands Hospital, Valhalla, N. Y., 1938-41; elected to associate membership by Central Medical Society.

STAUSS, CHALES ERNEST, Hattiesburg. Born Hallettsville, Tex. on July 18, 1937; M.D., University of Texas Medical Branch, Galveston, Tex., 1964; interned Brackenridge Hospital, Austin, Tex., one year; radiology residency, same, 1968-1970; elected by South Mississippi Medical Society.

WHITWELL, EARL E., Tupelo. Born Memphis, Tenn., on July 12, 1943; M.D., University of Mississippi School of Medicine, Jackson, Miss.,

1968; interned Mobile General Hospital, Mobile, Ala., one year; orthopaedic surgery residency, University Medical Center, Jackson, Miss., 1969-1973; elected by Northeast Mississippi Medical Society.



## DEATHS

JONES, A. D., Holly Springs. M.D., Howard University College of Medicine, Washington, D. C., 1950; interned Reynolds Hospital, Winston-Salem, N. C., one year; died Oct. 8, 1973, age 52.

TUBB, B. C., Smithville (E-RET). M.D., University of Nashville, Nashville, Tenn., 1909; member of Fifty Year Club of MSMA; Emeritus member of MSMA and AMA; died Oct. 13, 1973, age 95.



## PERSONALS

WILLIAM O. BARNETT and WILLIAM NEELY of Jackson and UMC participated in the meeting of the American Association for the Surgery of Trauma in Chicago. Dr. Neely presented a paper before the group.

RICHARD BORONOW of Jackson and UMC presented papers before the Las Cruces (New Mexico) Medical Society and the Central Association of Ob-Gyn in Scottsdale, Arizona, in October. HENRY THIEDE and DONALD SHERLINE of UMC were also participants in the Scottsdale meeting.

CHARLES EVANS CATCHINGS of Woodville was surprised with a birthday party on his seventy-fifth birthday by the staff of the Catchings Clinic and his family. Dr. Catchings has practiced medicine in Woodville for the past 48 years.

CARLOS M. CHAVEZ, associate professor of surgery at UMC, has been named a Fellow of the American College of Cardiology.

BYENG SUN CHOO announces the opening of his office for general practice, surgery and urology at 309 Auburn Avenue in Natchez.

ALTON B. COBB of Jackson, State Health Officer, has succeeded Seth Hudspeth as chairman of the Mississippi Interagency Commission.

C. EARL FOX, III, has been appointed director of the Tallahatchie, Coahoma and Grenada coun-



ty health departments. Dr. Fox, a native of Charleston, received his M.D. degree from the University Medical Center and completed a pediatrics internship there.

CHARLES FRALEY announces the opening of the Voice of Calvary Cooperative Health Center at 307 Center Street in Mendenhall.

ARMIN HAERER of Jackson and UMC attended a meeting of the Society of Clinical Neurologists in White Sulphur Springs, W. Va. in October.

JAMES D. HARDY of Jackson and UMC attended the Society of Clinical Surgery meeting in Minneapolis.

CHARLES H. HUBBERT has opened an office at 2200 South Lamar in Oxford for the practice of internal medicine, neurology and psychiatry. Dr. Hubbert will also serve as staff psychiatrist for the Region II Mental Health Center.

DOUGLAS W. LAMPPIN announces the opening of his office at Doctors Plaza Building, Suite 204, 4211 Hospital Road in Pascagoula for the practice of ear, nose and throat.

FRANCIS MORRISON of Jackson and UMC presented an invited paper, "Blood Component Therapy—1973," to the Southeastern Regional Meeting of the American College of Physicians at Sea Island, Ga. Dr. Morrison, JEANETTE PULLEN, BERNARD HICKMAN and TATE THIGPEN attended a recent meeting of the Southwestern Oncology Group in San Antonio.

WILLIAM NEELY of Jackson and UMC attended the 1973 meeting of the Southern Thoracic Surgical Association in Louisville, Ky.

NORMAN NELSON, dean of the UMC medical school, spoke at the American Urological Association postgraduate seminar in New Orleans.

BEN RADER, formerly practicing in New Orleans, has associated with the Hull Brothers' Clinic in Indianola for the general practice of medicine at 131 East Baker Street.

JOE ROSS and HERMAN KELLUM of Vicksburg are serving as members of the Board of Trustees for the new Vocational Education Complex to be built in Vicksburg.

JOHN F. RUSSELL of Gulfport, director of the Mississippi Gulf Coast Drug Abuse Center, was guest speaker at the Pass Christian High School assembly where he discussed drug abuse in Mississippi.

THOMAS A. QUIGLEY announces the opening of

his office for the general practice of medicine in Norwood Village, Gulfport.

EDSEL F. STEWART of McComb was elected first vice president of the Southwest Mississippi Junior College alumni association during homecoming activities at the college.

W. LAMAR WEEMS of Jackson and UMC attended a meeting of the AUA Council on Education and the Advisory Committee on Education, Allied Health Professions and Services, in Chicago.

ELBERT A. WHITE, III, of Corinth has been elected chief of staff and president of the Magnolia Hospital Medical Staff. TOMMY ALEXANDER was elected vice president and R. C. WIGGINTON, secretary. STANLEY HILL and T. L. SWEAT were named at-large members of the executive committee.

JULIAN WIENER and J. HARVEY JOHNSTON, JR., of Jackson served as chairmen for a special reception given in Jackson by Tulane Medical Alumni at which Tulane chancellor Dr. John J. Walsh spoke.

J. O. WOOD of McComb announces the association of MITCH MASSEY for the practice of radiology and nuclear medicine in Tylertown and McComb. Their office is located at 225 N. Front Street in McComb.

## Medico-Legal Briefs

### LAETRILE BANNED FROM INTERSTATE COMMERCE

A number of Mississippi physicians have recently contacted the state medical association office in regard to questions they have received from their patients concerning the treatment of cancer with Laetrile.

Laetrile, a compound consisting principally of amygdalin, a glucoside obtained from peach and apricot kernels, has been offered through various channels in the United States and Canada for the alleged control and treatment of cancer. Leading scientific and government sources have pronounced the treatment to be worthless and Laetrile is now contraband in interstate commerce.

The American Cancer Society reported in 1963: "... After careful study of the literature and other information available to it, the American Cancer Society has found no acceptable evidence that treatment with Laetrile results in any objective benefit in the treatment of cancer. ..."

The Food and Drug Administration states that it "has seen no competent, scientific evidence that Laetrile is effective for the treatment of cancer."

## MEDICO-LEGAL / Continued

Advocates of the Laetrile treatment claim that when amygdalin comes in contact with beta glucuronidase, an enzyme occurring in malignant tissues, a chemical reaction takes place that produces hydrogen cyanide. Advocates of the treatment state that the hydrogen cyanide thus formed prevents respiration of the malignant tissue and thus kills it, while normal tissues remain unaffected. They claim also that a deficiency of "Vitamin B<sub>15</sub>H<sub>8</sub>" (pangametin) and/or a deficiency of chymotrypsin, an enzyme secreted by the pancreas, are contributory factors in cancer.

Dr. E. T. Krebs, a leading exponent of Laetrile, is co-author of a paper which states that it is "possible to double the number of recoveries of cancer, when Laetrile and chymotrypsin are given with Vitamin B<sub>15</sub>H<sub>8</sub>." These theories stem from the writings of John Beard, a Scottish zoologist, who published in 1902 his belief that cancer cells are identical with the trophoblast cells that are produced in the body in the womb at an early stage of pregnancy. These cells, Beard alleged, are normally killed by pancreatic chymotrypsin, but a deficiency of this enzyme in the body will permit them to spread and become cancer.

The theory of the Laetrile treatment has been labeled invalid by competent researchers. Dr. Jesse P. Greenstein, late chief of the biochemistry laboratory of the National Cancer Institute, stated that the enzyme beta glucuronidase, alleged by Laetrile advocates to be concentrated in malignant tissues, is actually much more concentrated in the normal spleen and liver.

Four Canadian researchers, in a study published in the *Canadian Medical Association Journal*, May 15, 1965, reported that Laetrile had no significant effect on respiration of malignant tissues.

In addition to Dr. E. T. Krebs, other advocates and publicizers of the Beard theories and/or the Laetrile treatment have included: Dr. Krebs' son, E. T. Krebs, Jr., a biochemist; the John Beard Memorial Foundation, San Francisco, Calif., described by the Food and Drug Administration as an "association" between Dr. Krebs and his son; Howard H. Beard, Ph.D., director of the Beard Biochemical Laboratory, Fort Worth, Tex.; and the McNaughton Foundation, Montreal, Canada.

The Laetrile treatment has received substantial public notice through a series of magazine articles written by Glenn D. Kittler, and a book, "Laetrile: Control for Cancer" by the same author, which is sold in a paperback edition.

In November 1961, E. T. Krebs, Jr., and the John Beard Memorial Foundation were indicted

in San Francisco Federal Court for shipping in interstate commerce a misbranded drug, "pangamic acid, or Vitamin B<sub>15</sub>" that had not been cleared by the FDA. Krebs and the foundation pleaded guilty, and on May 5, 1962, were fined a total of \$3,755. Krebs was placed on probation for three years; one of the conditions of the probation was that neither he nor the foundation would make any interstate shipments of any new drug, including Laetrile, without an FDA-approved New Drug Application.

In 1963, E. T. Krebs, Jr., filed a New Drug Application with the Food and Drug Administration for Laetrile. The application was denied by the FDA because "the data submitted were inconclusive and insufficient to demonstrate either efficacy or safety."

In Canada, the McNaughton Foundation began to distribute Laetrile to physicians, but was prohibited from continuing such distribution by the Canadian Food and Drug Directorate. The Directorate contended that Laetrile was dangerous and did not meet the legal requirements for proof of efficacy and safety. In April 1964, the foundation secured a temporary injunction against enforcement of the CFDD's ruling, but in July, 1964, a Superior Court judge in Montreal lifted the injunction and upheld the right of Canadian food and drug officials to prohibit distribution of the drug. The effect of this ruling was to reinstate the Food and Drug Directorate's ban on distribution of Laetrile in Canada.

At this date, Laetrile is therefore contraband both in Canada and in interstate commerce in the United States.

### PHYSICIAN LIABLE FOR SIGNING FALSE COMMITMENT ORDER

A physician who signed an order committing a man to a hospital without ever seeing the man was liable for damages when the man was later arrested because of a letter to the local sheriff based on the physician's order, a Louisiana appellate court ruled.

After his wife signed a statement saying her husband was "mentally deranged," the man was detained in the hospital. His detention was based on an emergency detention form executed by the coroner. A local statute empowered the coroner to authorize an emergency detention for up to 30 days without a valid commitment order. The physician signed the coroner's commitment order as examining physician, even though he had never seen or examined the man.

Within 30 days the man was released from the hospital. Several weeks later he was arrested by



the sheriff, who was acting on the basis of a letter from the hospital director. The director stated that the man was on a coroner's commitment signed by the physician and should be returned to the hospital. This letter was written after the coroner's emergency detention order had expired.

An action was brought against the physician for damages sustained because of his falsely signing the coroner's commitment order. The man's confinement was caused solely by the coroner's

emergency detention form, the trial court said in ruling for the physician.

However, on appeal, the appellate court ruled that, although the original confinement was authorized, his later arrest and detention were the result of the hospital director's reliance on the falsely signed commitment order. The court rendered judgment of \$3,500 for the man's wrongful commitment.—*Keating v. Keller*, 242 So.2d 892 (La.Ct. of App., Dec. 21, 1970; rehearing denied, Feb. 5, 1971)

SCHEDULE OF UPCOMING  
NCME PROGRAMS

Here are the playing dates and upcoming programs to be distributed by The Network for Continuing Medical Education (NCME):

Dec. 3-  
Dec. 16      *Emergency Closed Tube Thoracostomy*, produced by the Center for Continuing Medical Education, Ohio State University College of Medicine in Columbus, Ohio.

*Diagnosing and Treating Strabismus*, with Virginia Lubkin, M.D., Ophthalmologist and Clinical Assistant Professor of Ophthalmology at Mt. Sinai School of Medicine in New York City.

*Drug Interaction: The Case of the Pushy Antibiotic*, with Harold C. Neu, M.D., Chief, Infectious Diseases, Columbia University College of Physicians and Surgeons, New York.

Dec. 17-  
Dec. 30      *Diagnostic Thoracentesis—Principles/Methods*, produced by the Center for Continuing Medical Education, Ohio State University College of Medicine, Columbus, Ohio.

*Lymphangiography in Diagnosis and Therapy*, with Robin Caird Watson, M.D., Chairman, Department of Diagnostic Radiology, Memorial Sloan-Kettering Cancer Center, and Associate Professor of Radiology, Cornell

University Medical Center, New York.

*Diagnosing Common Eye Inflammations*, with Virginia Lubkin, M.D., Ophthalmologist and Clinical Assistant Professor of Ophthalmology at Mt. Sinai School of Medicine, New York.

Dec. 31-  
Jan. 13      *The Exercise Prescription*, with Nanette K. Wenger, M.D., Professor of Medicine, Division of Cardiology at Emory University School of Medicine, and Director of Cardiac Clinics and Program for Cardiac Evaluation and Medical and Vocational Rehabilitation at Grady Memorial Hospital, Atlanta, Georgia; and William L. Haskell, M.D., Physiologist, Stanford University Medical School Heart Disease Prevention Program, Co-director, University of Stanford Cardiac Rehabilitation Program, Palo Alto, California.

*Skylab: Clinic in Orbit*, with Captain Joseph P. Kerwin, M.D., U. S. N., from NASA headquarters, Houston, Texas.

*Office Tests to Confirm Chronic Obstructive Lung Disease*, with Spence Koerner, M.D., Chief, Pulmonary Medicine, Montefiore Hospital and Medical Center, New York.

For more information about NCME, write The Network for Continuing Medical Education, 15 Columbus Circle, New York, N. Y. 10023.

# Gantanol® (sulfamethoxazole) and the

## 0.1 M.I.C.

### for three hours

Similar elongations occur regardless of antibacterial used.

## 1.0 M.I.C.

### for three hours

Similar midcell defects seen with increased antibacterial concentrations.

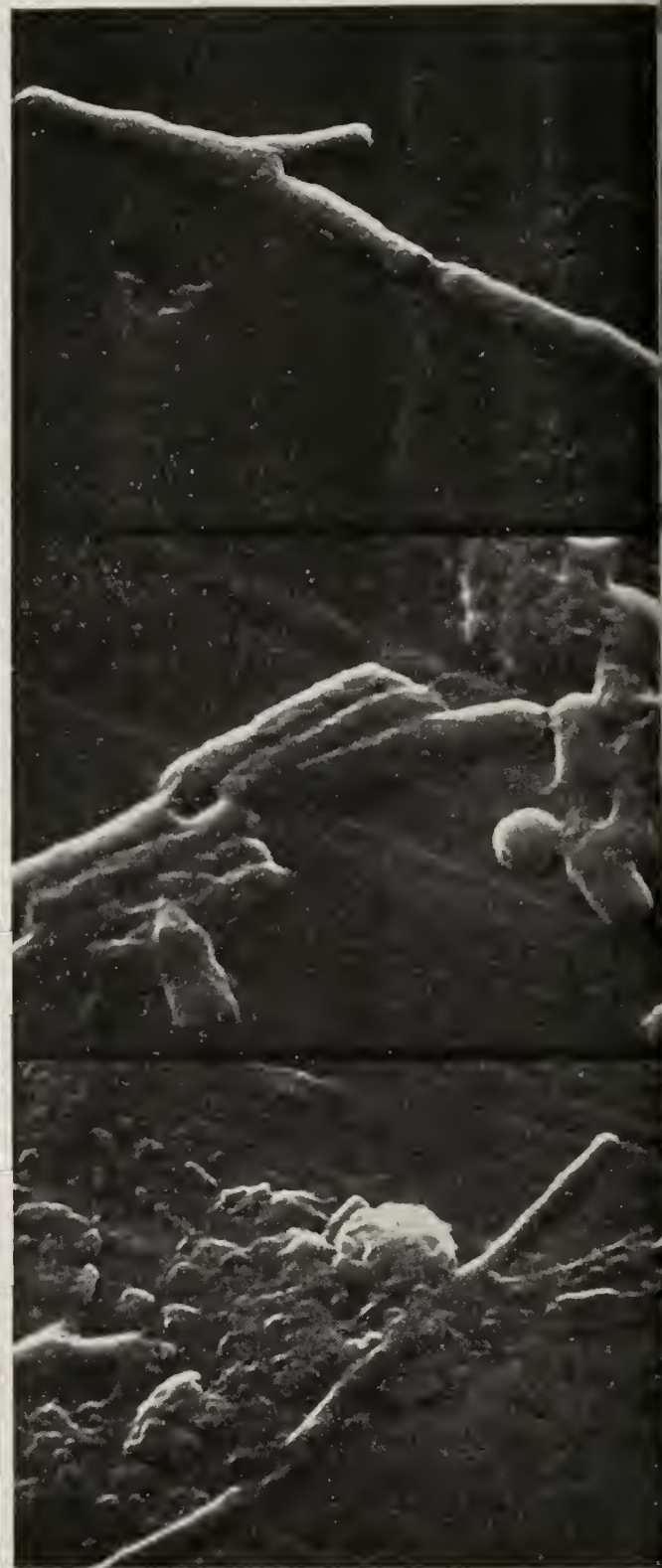
## 10 M.I.C.

### for three hours

Similar spheroplast-like forms appear with high concentrations of the antibacterials.



E. coli + sulfamethoxazole



E. coli + tetracycline

## The Scanning Electron Microscope (SEM) reveals the effect

**The *in vitro* experiment.** These SEM photomicrographs were taken as part of a study exploring the effects of various antibacterials with different modes of action on the surface morphology of bacteria. The scanning electron microscope was used because of its ability to show three-dimensional views of organisms, enabling better definition and appreciation of surface morphology.

For this portion of the experiment, *E. coli* were exposed to the following agents: sulfamethoxazole, a chemical drug which acts by interference with para-

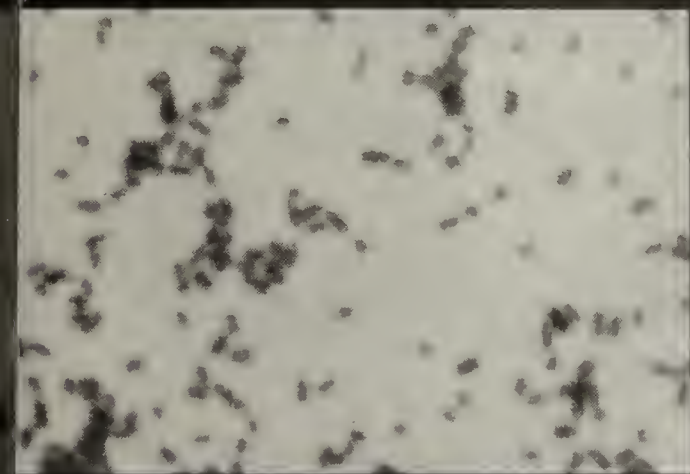
aminobenzoic acid utilization; tetracycline, which interferes with intracellular protein synthesis; and cephalothin and ampicillin, which are cell-wall-active drugs.

Strains of *E. coli*, each susceptible to the respective antibacterials, were exposed for 15, 30, 60, 120 and 180 minutes and 18 hours to several concentrations of each agent.

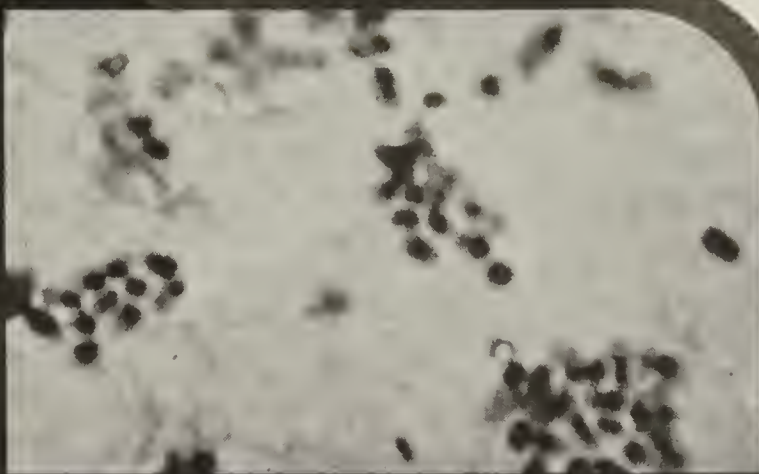
Following the 180-minute or three-hour exposures to the antibacterials at 0.1 M.I.C., 1.0 M.I.C. and 10 M.I.C., photoscans of the *E. coli* were taken. As shown above, regardless of the antibacterial agent used or its mode of action, the changes in surface morphology were remarkably similar... elongation at low drug concentrations, midcell defects at higher



# clinical practice



*Enterobacter* sp.—Gram stain showing characteristic gram-negative rod



*Proteus mirabilis*—Flagella stain

## ■ Your option: tablets or suspension

Gantanol Tablets or the pleasant-tasting, cherry-flavored Suspension can provide dependable antibacterial activity to control susceptible nonobstructed cystitis and pyelonephritis. Symptomatic improvement usually may be expected to begin within 24 to 48 hours. Usual precautions with sulfonamide therapy should be observed, including adequate fluid intake. Gantanol is generally well tolerated, with relative freedom from complications; the most common side effects are nausea, vomiting and diarrhea. Frequent c.b.c.'s and urinalyses with microscopic examination are recommended during therapy.

\*Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

In nonobstructed cystitis due to susceptible organisms

## Gantanol<sup>®</sup> B.I.D. (sulfamethoxazole) Basic therapy

binemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

**Dosage:** Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

*Usual adult dosage:* 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

*Usual child's dosage:* 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

**Supplied:** Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

## SBH Announces Reorganization Plan

State Health Officer, Dr. Alton B. Cobb, has announced that the Mississippi State Board of Health will undertake an extensive reorganization of its programs and departments based upon a plan for major reorganization of the agency approved by the State Board of Health at a recent meeting.

Under the two-phase plan, the department will first realign and consolidate existing programs. The present 13 major divisions of the department with their 32 programs will be consolidated into eight single purpose bureaus with clearly defined roles and responsibilities. This phase of reorganization will become effective immediately.

The second phase of the department's reorganization, which is the most extensive, will require three years and fiscal support from the 1974 Regular Session of the Mississippi Legislature. This phase will establish district-multicounty levels for planning and delivering services provided by the State Board of Health. The new State Board of Health districts will coincide with present EDA Planning and Development Districts.

The proposed reorganization plan reflects the input and thinking of persons both within and outside the State Board of Health and provides for implementation of many of the recommendations relating to improved local health services which were set forth in the Peat, Marwick, and Mitchell health agency study conducted for the Governor's Office of Comprehensive Health Planning in 1970 as well as other studies dealing with state government organization and administration. Dr. Cobb served as director of the Office of Comprehensive Health Planning during the 1970 study.



## Rondomycin® (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. **Gonorrhea** In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule. 900 mg initially, followed by 300 mg q i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



WALLACE PHARMACEUTICALS  
CRANBURY, NEW JERSEY 08512





# Mississippi Public Health Association Holds 36th Annual Convention

The thirty-sixth annual convention of the Mississippi Public Health Association was held Oct. 17-19 in Jackson at the Heidelberg Hotel with 684 public health workers attending the three-day meeting.

Presiding over the convention was Dr. Durward Blakey, director of the Preventable Disease Control Division at the Mississippi State Board of Health.

Keynote speakers were Dr. Norman Nelson, Vice Chancellor for Health Affairs and Dean of the School of Medicine at the University Medical Center, and State Senator Theodore Smith of Corinth. Dr. Nelson's speech centered around the convention theme, "Public Health: The Heart of the Community," and Senator Smith presented a number of interesting remarks on "Governmental Responsibility for Public Health Practice."

The close of the Wednesday session was highlighted by the presentation of 48 service awards to public health employees who have 25, 30 and 40 years of service with the state and/or local health departments. Dr. Alton B. Cobb, in his first appearance before MPHA as Mississippi's State Health Officer, made these presentations.

"Professional and Legislative Liaison Programs in Tennessee" was the topic explored Thursday morning at the General Session when H. P. Hopkins, Ph.D., with the Tennessee Department of Public Health, talked to the group. Dr. Hopkins is Assistant Commissioner for Policy Planning for the department. Also on the program was Dr. Fred Hering, executive secretary with the South-

ern Branch of APHA, Birmingham, Ala. He extended "greetings from Southern Branch" and expressed continued support for Mississippi's health programs. On Thursday afternoon, the convention divided into section meetings according to disciplines and an outstanding array of speakers and panel participants took part in the various sections.

The Friday morning session heard from Alabama's State Health Officer, Dr. Ira S. Myers, who shared ideas and suggestions on public health reorganization in Alabama. Following Dr. Myers, Rufus F. Davis, Associate Commissioner for Administrative Affairs, Georgia Department of Human Resources, presented Georgia's health reorganization picture. Both speakers' remarks were timely due to the planned reorganization now underway at the Mississippi State Board of Health.

At the close of the convention newly-elected officers were presented to the session and installed by the outgoing president, Dr. Blakey.

They are: president, Joe Brown, MSBH; vice-president, Dr. Durward Blakey, MSBH; president-elect, T. W. Williamson, MSBH; secretary, Leslie Magee, MSBH; treasurer, T. W. Williamson, MSBH; administrative section chairman, Terry Beck, MSBH; community health services chairman, Richard Barba, Jackson; clerical section chairman, Mrs. Nina Bouler, Washington County Health Department; sanitation section chairman, Leland May, MSBH; public health nursing section chairman, Miss Martha Campbell, MSBH.



*New officers of the Mississippi Public Health Association are from left, seated: Mrs. Nina Bonler, Washington County Health Department, clerical section chairman; Joe Brown, MSBH, president; Miss Martha Campbell, MSBH, public health nursing section chairman; standing from left: Terry Beck,*

*MSBH, administrative section chairman; Richard Barba of Jackson, community health services section chairman; Leland May, MSBH, sanitation section chairman; Dr. Dnrward Blakey, MSBH, vice president; T. W. Williamson, MSBH, treasurer and president-elect; and Leslie Magee, MSBH, secretary.*

## Dr. R. J. Field Named ACS Governor for State

Three officers and 54 new members of the Board of Governors of the American College of Surgeons were elected at the recent annual Clinical Congress of the college held in Chicago, bringing the total number of governors to 194. The new ACS governor for Mississippi is Dr. Richard J. Field, Jr., of Centreville.

Attendance at this world's largest meeting of surgeons was 16,723, with physicians' registration 10,073.

Dr. Robert C. Hickey, Houston, and Dr. David C. Sabiston, Jr., Durham, N. C., were elected chairman and vice-chairman, respectively, of the Board of Governors. Dr. Luis F. Sala, Ponce, Puerto Rico, was elected secretary, replacing Dr. Sabiston.

Also elected to the executive committee was Dr. Donald M. Gallagher, San Francisco, Dr. Franklin L. Shively, Jr., Dayton, Ohio, and Dr.

Colin Campbell Ferguson, Winnipeg, Canada.

Governors act as communication links between the 35,000 Fellows (members) of the college, 80 chapters, specialty societies, Regents (the 19-member policy-making body of the college) and headquarters staff. They represent each state in the United States, each Province of Canada, any country with more than 15 Fellows, 52 related surgical associations and societies, and the federal medical services.

Governors serve a three-year term, and may not serve more than two terms in succession.

President of the college is Dr. Claude E. Welch, Boston; Dr. Frank E. Stinchfield, New York, is chairman of the Board of Regents. Dr. C. Rollins Hanlon, Chicago, is director.

## Medical Center Names New Associate Deans

Two associate deans have been named at the University of Mississippi School of Medicine. Dr.



Henry A. Thiede and Dr. Carl G. Evers are the new appointees at the University Medical Center, according to vice chancellor Dr. Norman Nelson. An increase in enrollment of almost 50 per cent over the past five years brought about the need for the two new positions.

Dr. Thiede, assistant dean and chairman of the Department of Obstetrics and Gynecology, is the new associate dean for academic affairs. Dr. Evers, associate professor of pathology, is assuming duties of associate dean for student affairs.

Dr. Thiede came to the University Medical Center from the University of Rochester School of Medicine where he taught 11 years in the obstetrics and gynecology department. He has been professor and chairman of the Medical Center's department since he came to Jackson in 1967. He has also served as an assistant dean since 1970.

The new associate dean is a fellow of the American College of Obstetrics and Gynecology and a member of Sigma Xi and the Society for Gynecologic Investigation.

Dr. Evers, a native of Minnesota, has taught in the Medical Center's pathology department since 1964. A graduate of Mankato College, he received his M.D. degree from the University of Minnesota Medical School.

Dr. Evers came to the University Medical Cen-

ter in 1959 for his internship and residency. He is a member of the International Academy of Pathology and the American Association for Advancement of Science.



## LETTERS

SIRS: I am currently editing three books, i.e., the prevention and treatment of the medical problems of golfers, the prevention and treatment of the medical problems of swimmers and the prevention and treatment of sports medical problems in general. They are to be written by physicians for the sports minded laymen. I would appreciate hearing from anyone wishing to contribute a chapter to any and/or all of these books or who would be able to suggest someone to contribute chapters to these books.

CLAUDE A. FRAZIER, M.D.  
4-C Doctors' Park  
Asheville, N. C. 28801

SIRS: On Friday, Sept. 14, 1973, a family of seven from Hinds County was taken to a local hospital by ambulance after being found unconscious by a relative. The family had been well until an evening one week previously when they first noted that the entire family had headaches. They continued to feel unwell until the next day when their symptoms abated during the course of their normal daily activities. The following evening the same symptoms—lassitude, headache and malaise—recurred and several children experienced nausea and vomiting. Once again the symptoms abated during the day and recurred at night. The following evening two family members consulted a physician who noted fever (101°-102° F.) and prescribed symptomatic treatment for their presenting complaints of malaise, nausea and vomiting. The following evening the entire family again noted headache, malaise and intermittent nausea and vomiting, and later the same night—dizziness and syncope. The following morning the entire family remained at home. Later that afternoon they were found by a relative to be unconscious and were rushed to a nearby hospital.

In the emergency room the entire family was found to be stuporous and febrile (see Table 1). Several children were noted to have flushed skin color. Two family members were given nasal oxygen and all had normal chest x-rays. All seven family members were admitted for observation after a diagnosis of carbon monoxide poisoning



*Dr. Carl G. Evers, left, and Dr. Henry A. Thiede, right, are new associate deans at the University Medical Center. Dr. Evers is associate dean for student affairs; Dr. Thiede is the new associate dean for academic affairs.*

## LETTERS / Continued

was made. The following morning they were afebrile, completely recovered, and were discharged. (Reported by: J. Dan Mitchell, M.D., Jackson, Robert B. Ireland, M.D., Clinton, Eric McVey, M.D., director, Hinds County Health Department and Hinds County Sanitation Department, and Arthur Hume, associate professor of pharmacology and toxicology, University Medical Center.)

Representatives from the Hinds County Health Department and a local utility company visited the home of the family and found both a leaking hot water faucet and an improperly vented gas hot water heater. The leaking faucet was thought to have caused the hot water heater to operate continually. Carbon monoxide (CO) levels were measured (after the house had been ventilated by open doors and windows for several hours) and found to be markedly elevated (0.1 volume per cent or 1000PPM). Carboxyhemoglobin levels were measured on blood obtained in the emergency room by the toxicology department at the University Medical Center (see Table 1) and were elevated in every instance.

TABLE 1  
LABORATORY FINDINGS IN FAMILY MEMBERS  
WITH CO POISONING

Family Member	Age	Temperature Upon Admission (F)	WBC	Urinalysis	COHb Level (Per Cent)
1	12	101	10600	3+ protein 10-15 WBC/HPF Trace glucose	15.0
2	36	101	7200	Normal	18.6
3	11	102 <sup>6</sup>	7600	Normal	18.5
4	14	101 <sup>6</sup>	8900	Normal	17.0
5	40	102 <sup>6</sup>	10900	1-2 RBC/HPF 4-6 WBC/HPF	19.0
6	17	100 <sup>4</sup>	10400	Trace glucose	17.0
7	15	101	12600	Normal	20.0

It is generally not appreciated that carbon monoxide poisoning can produce fever, leukocytosis, and an abnormal urinary sediment. A diag-

nosis of carbon monoxide poisoning was not initially considered when several family members presented with gastrointestinal complaints and fever. Only when mental changes occurred several days later and several children were noted to have a slightly flushed appearance did the diagnosis become apparent.

The usual signs and symptoms of carbon monoxide poisoning are those characteristic of hypoxia and correlate well with the COHb content of blood.<sup>1</sup> Early symptoms of toxicity include headache, weakness, dizziness, dimness of vision, nausea, vomiting and syncope. Symptoms such as coma, intermittent convulsions and Cheyne-Stokes respirations usually occur with COHb levels greater than 50 per cent. Death can occur with COHb levels from 60 to 80 per cent.<sup>1</sup>

Rarer clinical findings include skin lesions, excessive sweating, hepatomegaly, hemorrhage, leukocytosis, albuminuria, glucosuria and an abnormal urine sediment. Meigs and Hughes found that 17 of 105 patients with CO poisoning had temperatures of 102° F. or greater.<sup>2</sup> Alternately, British physicians in World War I reported that CO initially caused a depression of body temperature associated with sensations of chilliness. Later, as recovery occurred, temperatures as high as 104° F. were recorded and in some cases pyrexia lasted up to several days after terminating exposure to CO.<sup>3</sup> Finck noted fever in 14 of 37 cases of CO poisoning. A temperature of 108° F. was found in one case just prior to death.<sup>4</sup>

The source of CO in the household of the affected family was thought to be fumes derived from combustion of natural gas in an improperly vented water heater and not from leaking unburned natural gas. In the United States natural gas does not contain CO.<sup>4</sup>

DURWARD L. BLAKEY, M.D.  
Director, Division of  
Preventable Disease Control  
State Board of Health

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3. Meigs, J. W. and Hughes, J. P. W.: Acute Carbon Monoxide Poisoning: An Analysis of One Hundred Five Cases. A.M.A. Arch. Ind. Hyg. 6:344-356, 1952.
4. Finck, P. A.: Exposure to Carbon Monoxide: Review of the Literature and 567 Autopsies. Milit. Med. 131:1513-1539, 1966.





# Woman's Auxiliary to the Mississippi State Medical Association

## A CHRISTMAS THOUGHT . . .

Each year I learn a little more of love,  
Its joys, sorrows, trials, ecstasies.  
From day to day I chance upon its friends  
And likewise do I meet its enemies.

Sometimes without, sometimes within my heart  
Temptations come to taunt, to bite and sting.  
But ever soothing is the Voice that says:  
Love is a giving, not a getting thing.

And who can take away a love which I  
Am glad to give, that like the oil and meal  
Is constantly replenished by that Source  
That keeps it ever flowing, pure and real?

—EVELYN H. PENDLEY, Rome, Georgia (a doctor's wife)

## A NEW WISH FOR YOU . . .

I sing a song to pioneers of peace,  
A New Year song to you who dare to dream  
Of dawning days when crimson war shall cease  
And beacon lights of right again shall gleam.

Beneath the breast of you who live to heal,  
No passive spirit quails in dire dismay.  
True patriots, true democrats, you feel  
The romance of your calling, day by day.

God give you courage for your task in hand.  
God shield you from the tyranny of State.  
As sturdy individuals may you stand  
For those proud principles which made you great.

Be still a boon to those who suffer pain.  
Give hope and comfort where the way seems dark.  
Be men of God in body, heart and brain,  
The kind of men mankind delights to mark.

I sing a song to pioneers of peace  
A New Year song to pulse from soul to soul.  
Of wisdom Heaven give you high increase  
And strength, at length, to gain your dearest goal.

—DAVID E. GUYTON (Written by request for  
*The Mississippi Doctor*, January, 1941)

JANE PRESTON  
(Mrs. William H. Preston, Jr.)  
President, Woman's Auxiliary

## Russian Physician Visits Medical Center



Dr. Valeriy I. Schumakov, at left, who heads the department of transplantation and artificial organs at the Research Institute of Clinical and Experimental Surgery in Moscow, was at the University of Mississippi Medical Center for conferences with Dr. Tetsuzo Akutsu, right, professor of surgery (research) in November. The two are among the world's principal researchers on the total artificial heart. Dr. Akutsu and his team currently hold the international record for animal survival with the manmade device.

## Nurse Anesthetists Remain in State

The first nurse anesthetists to get training in Mississippi are all practicing in the state, according to Dr. Thomas E. Freeland, dean of the School of Health Related Professions at the University Medical Center.

They have located in Meridian, Sardis, Brandon and Jackson.

"The program at the Medical Center was established to meet Mississippi's need for nurse anesthetists," Dr. Freeland pointed out, "so it is significant that all members of our first graduating class elected to remain in the state."

Six were in the first graduating class. They included Ms. Comita Williams of Meridian and Ben Jones of Centreville, both now based in Meridian; Ms. Nell Vick of Charleston, who is practicing in Sardis; Ms. Frenchie Alderman of Jackson, now at Rankin General Hospital in Brandon; and Ms. Helen McCarty and Ms. Virginia Sou-

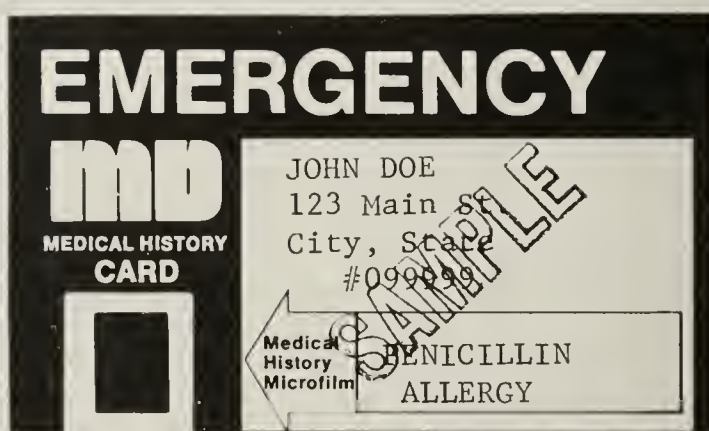
deres, both of Jackson and now on the nurse anesthesia staff at Hinds General Hospital.

Ms. Georgie Coleman heads the Medical Center's two-year training program in nurse anesthesia. Instruction includes training in administration of anesthesia for surgery, including obstetrics and dentistry, under physician direction. A new class is enrolled each May, and any registered nurse may apply for admission.

## MD Card Has Lifesaving Potential

A simple, wallet-sized card with lifesaving potential is now available to everyone for less than the cost of some books on first aid.

The MD Card, newly developed by Medical Identification Systems, Inc., contains a complete medical history of the bearer on microfilm. It enables persons afflicted with a cardiac condition, allergies, diabetes or other pre-existing medical problems to be assured of proper treatment by medical personnel in emergency situations.



Data appearing on the MD Card is developed from information supplied by the subscriber and includes Social Security number, health and accident insurance policy data, family physician, next of kin, blood type and pre-existing medical conditions.

This information is placed on a microfilm and laminated into the card with the name and address of the subscriber. If the person has a pre-existing medical problem, a large arrow is placed on the card alerting medical personnel to the condition. This warning is designed to "flag down" the attention of doctor, nurse or ambulance attendant and help save the bearer's life in an emergency.

Medical data contained on the MD Card's microfilm can be read with a microfilm reader, low-powered microscope or hand magnifier. Virtually all hospitals have such equipment available. In



the event that it is not available, Medical Identification Systems, Inc., maintains 24-hour, 7-day-a-week telephone service to provide a verbal read-out of the information on the subscriber's medical history form.

The MD Card is available to individual subscribers for a \$5.00 fee and there are lower prices for group purchases. In addition to the card itself, the fee includes the storage of microfilmed medical data for an unlimited period. In the event of a lost card or a change in the subscriber's medical history, a new card is issued at half price. There are no annual dues.

Heretofore, bracelets or medallions have been available to persons with pre-existing medical conditions who are concerned about emergency medical treatment. However, those wearing single purpose bracelets or medallions have found that neither device permits the inclusion of a complete medical history and a number of wearers find that the bracelet and medallion do not protect the confidentiality of their medical problems.

Further information on the MD Card, including a Medical History Form, is available from Medical Identification Systems, Inc., 880 Third Avenue, New York, N. Y. 10022, (212) 867-8888.

## Inderal Is Now Used in Angina

Inderal, brand of propranolol, a beta-adrenergic blocker that has been used extensively for the last five years in the treatment of supraventricular arrhythmias, is now being used very effectively in the management of patients with moderate to severe angina pectoris who have not responded to conventional treatment, according to Ayerst Labs.

In responsive patients, Inderal will decrease frequency of anginal attacks, reduce the need for nitroglycerin, and increase pain-free effort tolerance, thereby helping the angina patient to engage in the activities of daily living.

## West Miss. Medical Society Meets



*Dignitaries confer at the fall meeting of the West Mississippi Medical Society in Vicksburg. From left are Drs. M. E. Hinman of Vicksburg, secretary-treasurer; Tom H. Mitchell of Vicksburg, delegate to AMA; Arthur A. Derrick, Jr., of Durant, president of the Mississippi State Medical Association and*

*special guest of the society; F. T. McPherson of Vicksburg, WMMS president; Karl W. Hatten of Vicksburg, program chairman; and W. R. Gillis of Jackson, chairman of the family practice department at the University Medical Center and guest speaker for the evening.*



**Because you  
practice  
medicine in the  
Magnolia State...**



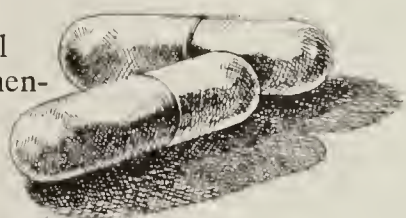


**You carry one of the heaviest patient loads in the country. Since this may include a number of patients with gastritis and duodenitis... you should know more about Librax®**

### **Helps reduce anxiety-related G.I. symptoms**

A patient may blame his attacks of gastritis or duodenitis on "something he ate" but contributing factors may be his job, marital problems, financial worries or some other unmentioned source of stress and excessive anxiety that exacerbated the condition.

Whether it is "something he ate" or "something eating him," adjunctive Librax can help. Librax offers both the antianxiety action of Librium® (chlordiazepoxide HCl), that can help relieve excessive anxiety, and the dependable anticholinergic action of Quarzan® (clidinium Br), that can help reduce gastrointestinal hypermotility and hypersecretion.



### **Patient-oriented dosage — up to 8 capsules daily in divided doses**

For optimal response, dosage can be adjusted to suit patient needs—1 or 2 capsules, 3 or 4 times a day.

## **To help relieve anxiety-linked symptoms in gastritis and duodenitis**

**adjunctive Librax®**



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions

in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, New Jersey 07110

## ACS Inducts 15 State Surgeons

The largest number of surgeons in the history of the college—numbering 1,675 including 15 Mississippians—were inducted as new Fellows (members) of the American College of Surgeons in cap-and-gown ceremonies during the annual five-day Clinical Congress of the world's largest organization of surgeons at Chicago.

Fellowship, a degree entitling the recipient to the designation "F.A.C.S." following the doctor's name, is awarded to those surgeons who fulfill comprehensive requirements of acceptable medical education and advanced training as specialists in one of the branches of surgery, and who give evidence of good moral character and ethical practice.

Initiated from Mississippi were: Major Donald J. Booth, USAF MC and Ray L. Wesson of Biloxi; Joseph E. Roe of Oxford; Charles H. Crocker of Bruce; S. R. Evans, Jr., of Greenwood; Magruder S. Corban and John E. Williams of Gulfport; W. Meredith Bradford, Heber C. Ethridge, Lucien R. Hodges, Myron W. Lockey, and Charles D. Scruggs of Jackson; C. Foster Lowe of McComb; William A. Billups, Jr., and W. Cecil Johnson, Jr., of Meridian.

The American College of Surgeons is a voluntary scientific and educational association of surgeons, numbering 35,000 in approximately 100 countries. The college was founded in 1913 to improve care of the surgical patient, and has pioneered in many directions in making surgical care as excellent as it is today.

## Choctaw Children Get Hearing Tests

More than 1,500 Choctaw children will get a hearing test this year in a new tribal effort aimed at finding middle ear infections.

The inflammation is the second most common illness among American Indians—including the Mississippi Choctaws. Left untreated, it can eventually cause permanent hearing loss.

Screening technician for the special program, supported by a contract from the Indian Health Service to the Mississippi Band of Choctaw Indians, is Darry Williams of Philadelphia. He re-

ceived training in a month-long course at the University of Mississippi Medical Center communicative disorders laboratory.

"We don't know why middle ear disease occurs so often in the American Indian," points out Dr. Ojus Malphurs, who heads the UMC communicative disorders lab. "It may be a genetic problem—an inherited abnormality in ear structure, environmental conditions or simply not getting medical care soon enough."

Williams began the screening program in October by testing the hearing of children between the ages of 5 and 18 for any general abnormalities. Referrals to a physician for treatment will be made for youngsters found to have the infection.

"Middle ear infection," said Dr. Malphurs, "can easily be treated before damage is done. Early diagnosis is the answer."

Tribal Chairman Phillip Martin explained, "This screening program is administered by the Tribal Council and is the first in a series of on-reservation health screening programs."

## Otolaryngology Council Aids Placement

Any community needing an otolaryngologist is invited to contact the American Council of Otolaryngology for help.

The council does not promise to produce an immediate prospect, but it does pledge that it will call the community's need to the attention of senior residents in otolaryngology who are known to be looking for practice opportunities.

Doctors in private practice, medical groups and all individuals commissioned by their medical communities to search for an otolaryngologist should briefly outline the position available when writing the council.

There are two ways in which the council can advise otolaryngologists of the community need, Dr. Raymond E. Jordan, executive director, explained:

(1) It can notify directly those senior otolaryngology residents who have specifically advised the council that they are looking for a position.

(2) It can further communicate the community's need through a newsletter reaching all practicing otolaryngologists in the United States and Canada.

Letters should be addressed to: The American Council of Otolaryngology, Suite 602, 1100 17th St., N. W., Washington, D. C. 20036.



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## Marion Labs Offers CVD Learning System

A new learning system about cerebral vascular disease, now available to physicians or physician groups from Marion Laboratories, Inc., has been announced by the pharmaceutical company. The learning system consists of a color film, "Diagnosis and Treatment of Cerebral Vascular Insufficiency," together with a supply of monographs that accompany the film. The monograph serves as a convenient review of information in the film and contains a quiz to be self-administered.

The film is suitable for continuing education credit hours from the American Academy of Family Physicians and the American Medical Association. It discusses the prognostic value of the various indications in the stroke-prone profile; describes the work-up of the patient diagnosis in cerebrovascular disease, including the use of cerebral angiography; describes the categories in the differential diagnosis of cerebrovascular disease; explores current modes of therapy in the management of acute thrombotic stroke; describes medical therapy, including the use of anticoagulants, platelet inhibitors, and glycerol, and discusses surgical treatment.

The editorial committee for the film consists of Drs. Clark H. Millikan, Michael E. DeBakey, Lawrence C. McHenry, Jr., and John Stirling Meyer.

Physicians may obtain the film without charge for viewing themselves or for showing to physician groups by writing Professional Services, Pharmaceutical Division, Marion Laboratories, Inc., P. O. Box 9627, Kansas City, Mo. 64134.

## St. Paul Studies Malpractice Problem

A special effort to diagnose and treat the problem of escalating medical malpractice losses has been announced by one of the leading sources of medical liability insurance, St. Paul Fire and Marine Insurance Company.

President Waverly G. Smith said The St. Paul was initiating a program designed to help doctors prevent incidents which lead to malpractice claims and to speed up the disposition of cases.

The major elements of the program are:

(1) Arbitration will be advocated as a speed-

ier and less costly claims settlement practice. Doctor-patient and hospital-patient arbitration agreements will be sought in jurisdictions showing interest and where arbitration is a practical approach. Model agreements have been prepared by The St. Paul. The company believes arbitration decisions should be based on medical expertise.

(2) Special materials alerting doctors to current trends and unusual exposures will be produced. These will be aimed at helping doctors prevent injuries and at assisting in doctor-to-patient communications.

(3) Claims data will be computer programmed to aid in the identification of medical liability trends and recurring causes of losses. Information obtained will be used in developing loss prevention information for doctors.

(4) Formation and use of medical review panels by state medical associations will be more strongly encouraged and assisted where requested. The St. Paul endorses review panels of medical personnel designed to aid the company in determining whether a departure from the standard of medical care occurred.

(5) Techniques and materials to enable doctors to obtain good informed consents from their patients will be given special attention. The company believes that a well informed patient is less likely to assume that less than successful results from surgery or other treatment automatically means the doctor was negligent.

"Malpractice is an ugly word," Smith observes. "But even a skillful and conscientious physician may become a defendant, due to the action or inaction of medical personnel for whom the doctor is responsible; because of a breakdown in communications with a patient, or as a result of unrealistic patient expectations of guaranteed successful treatment."

As one of the leading insurers of the medical profession, The St. Paul's claims experience indicates there are a number of things doctors can do in daily practice and patient communications to reduce the potential for malpractice claims.

"The St. Paul is also convinced that a doctor's chances of becoming a defendant in a malpractice action will be greatly reduced if the malpractice problem is understood from the patient's point of view and if the physician's legal responsibilities to the patient are clearly recognized," Smith said.

For malpractice claims where there is disagreement over whether negligence actually occurred or the amount of damages, Smith said arbitration procedures could reduce the time otherwise spent waiting for litigation to move through the usual legal process.











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